

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03126

CERTIFICATE OF DEATH

03117

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 39 Murdock Rd.		d. STREET ADDRESS 39 Murdock Rd.	
3. NAME OF DECEASED (Type or print) Grace Reese Agnew		4. DATE OF DEATH Month 3 Day 3 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/92
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orlando Reese		14. MOTHER'S MAIDEN NAME Josephine Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-3950	
17. INFORMANT Miss Olga G. Agnew-		Address 39 Murdock Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rectum with Pelvic Metastases DUE TO (b) 154X DUE TO (c) metastases		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from Feb. , 19 67 , to Mar. , 19 67 , that (I) (we) saw the deceased alive on Feb. 24 , 19 67 , and that death occurred at 11 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Wm. H. Kammer, Jr.		22b. DATE SIGNED 3/3/67	
22c. PHYSICIAN'S NAME (Type) William H. Kammer, Jr.		22d. ADDRESS 6011 York Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/6/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Robert C. Altenburg - 6009 Hartford Rd.		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03113

03113

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03127						03118					
1. PLACE OF DEATH a. COUNTY BALTIMORE Co. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				d. STREET ADDRESS 15 WARREN Lodge Ct. Apt 2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater BALTIMORE Medical Center											
3. NAME OF DECEASED (Type or print) Baby Girl			First Middle Last ALLSTON			4. DATE OF DEATH MARCH 11 1967			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 11 1967		9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 11 Days 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) BALTO. Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME FRANCIS G. ALLSTON JR.						14. MOTHER'S MAIDEN NAME VELMA Faye Godbee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. —		17. INFORMANT Address MOTHER'S CHART - Above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 Congenital heart disease DUE TO (b) congenital heart disease DUE TO (c) pulmonary vein stenosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/11, 1967, to 3/11, 1967, that (I) (we) last saw the deceased alive on 3/11, 1967, and that death occurred at 3:30 M, from the causes and on the date stated above.											
22a. SIGNATURE Margaret E. Lang, M.D.						M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) MARGARET E. LANG, M.D.						22b. DATE SIGNED 3/11/67					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF MAR. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City, town or county) (State) Adem's Run, S. Carolina			
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.						25a. REC'D BY REGISTRAR DATE MAR 15 1967		25b. REGISTRAR'S SIGNATURE John Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach remaining papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G386 3/20/67

03128

CERTIFICATE OF DEATH

03119

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21212 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 d. STREET ADDRESS 202 Hollen Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jennie		4. DATE OF DEATH Month March Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 February 23, 1884
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Charles Fazio		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-28-0830	
17. INFORMANT Mrs. Leonard DeCato, 3208 Northway Dr. Balto. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Congestive heart failure secondary to DUE TO (b) Arteriosclerotic heart disease. DUE TO (c) Arteriosclerotic heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
19. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that we (this hospital) attended the deceased from March 11, 1967 to March 14, 1967 that we (we) last saw the deceased alive on March 14, 1967 , and that death occurred at 12:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Ernesto Hipolito		22b. DATE SIGNED March 14, 1967	
22c. PHYSICIAN'S NAME (Type) Ernesto Hipolito, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/67.	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REG. BY REGISTRAR APR 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

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FOR STATE
MEDICAL DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any person is necessary to execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 to the funeral home, and Page 5 to the State Department of Health. This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, and in any event within 72 hours after death.

Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15ME
5M 1/62

MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03129											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY in lb 19 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 22				d. STREET ADDRESS 3420 Dunhaven Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Joseph Hospital											
3. NAME OF DECEASED (Type or print) Mary First M. Middle Anderson Last						4. DATE OF DEATH Month March Day 21 Year 19 67					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/28/89		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME Edward Clark						14. MOTHER'S MAIDEN NAME Lena Housner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-07-5551		17. INFORMANT Mrs. Gertrude Marecki				Address 7538 Berkshire Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 90 40 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Comminuted fracture of left femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) fell							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3/2 67 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Baltimore		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) William A. Pillsbury Timonium, Md. DATE SIGNED 3/21/67											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-25-1967		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel				22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Lilly & Zeiler Inc.						ADDRESS 1901-07 Eastern Ave.		24a. REC'D BY REGISTRAR MAR 23 1967		24b. REGISTRAR'S SIGNATURE J. Charles Judge	

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

517-17-0003

1995/1996, 2000/2001

Cheng, D. 2007. 3/5

References

03130

CERTIFICATE OF DEATH

03121

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>1215 Cedarcroft Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>D.</u> Last <u>Anello</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1890</u>
9. AGE (in years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley Delligo</u>		14. MOTHER'S MAIDEN NAME <u>Anna Anello</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Antonio Anello</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-14-1967</u> , to <u>2-14-1967</u> , that (I) (we) last saw the deceased alive on <u>2-14-1967</u> , and that death occurred at <u>10:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence M. Serra</u>		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence M. Serra, M.D.</u> <u>11 East Chase Street,</u>		22d. ADDRESS <u>Baltimore, Maryland 21202</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 20 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08180

08180

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detailed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03131		Item #2d Film #3307 4/4/67 pg				03122			
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. Joseph Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>10 Park Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>M.</u> Last <u>ATKINSON</u>			4. DATE OF DEATH Month <u>3</u> Day <u>28</u> Year <u>1967</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 23, 1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George GRINDELL</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN SHARON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. MARGARET A. BRADY</u>		Address <u>10 PARK DR. #28</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis C.V.D.</u> <u>Hx of</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>54</u> to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>67</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>J. C. Pound</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/29/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. C. Pound</u>				22d. ADDRESS <u>3325 Frederick Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>			
24. FUNERAL DIRECTOR <u>E.S. MacNabb</u>				ADDRESS <u>301 Frederick Rd</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



03132

CERTIFICATE OF DEATH

03123

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 21218		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2327 N. Charles St	
3 NAME OF DECEASED (Type or print) Mary V. BAGLEY		4. DATE OF DEATH Month March Day 18 Year 1967			
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 19, 1910		9. AGE (in years last birthday) 56 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-28-3585		17. INFORMANT Family Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction DUE TO pulmonary thrombo-embolism (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that he (this hospital) attended the deceased from March 6 , 19 67 , to March 18 , 19 67 , that he (we) last saw the deceased alive on March 18 , 19 67 , and that death occurred at 12:15am M, from causes and on the date stated above.					
22a. SIGNATURE Reynaldo Orjuela-Gomez, M. D.		22b. DATE SIGNED March 18, 1967		22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M. D.	
22d. ADDRESS 7620 York Road, Towson 4, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 20 MAR. 1967	23c. NAME OF CEMETERY OR CREMATORY MAY'S CHAPEL CEMETERY		23d. LOCATION (City or Town) (County) (State) LUTHERVILLE, MD.	
24. FUNERAL DIRECTOR John Burns Sons, Towson, Md.		25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

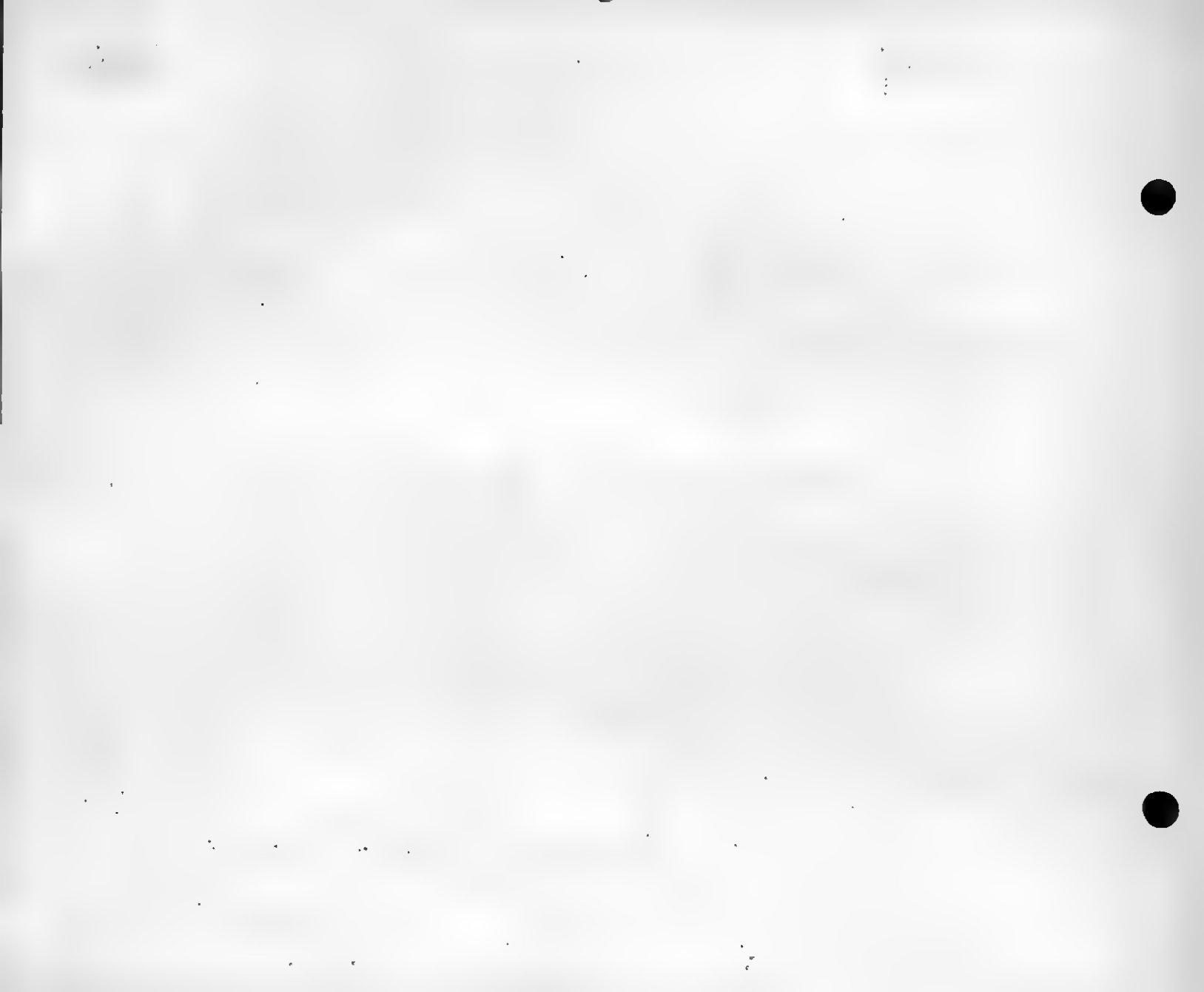


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03133											
03124											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 21 DUNMORE RD.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 21 DUNMORE RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First EDWARD Middle E. BAILEY Last 4. DATE OF DEATH Month MARCH Day 11 Year 1967						5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH SEPT. 1, 1909 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLAIMS CHECK 10b. KIND OF BUSINESS OR INDUSTRY J.S. ADH. 11. BIRTHPLACE (County & State, or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME EDWARD BAILEY 14. MOTHER'S MAIDEN NAME ANNA EDENFIELD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Dorothy C. Bailey - 21 Dunmore Rd. Address						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) QUE TO (c) QUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (this hospital) attended the deceased from Nov. 19 65 , to 3/11 19 67 , that (I) (we) last saw the deceased alive on 3/11 19 67 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE John H. Toohy 22b. DATE SIGNED 3/13/67						22c. PHYSICIAN'S NAME (Type) JOHN H. TOOHY, M.D. 22d. ADDRESS ST. AGNES HOSP., BALTO MD 21229					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-14-67 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery 23d. LOCATION (City, town or county) (State) Woodlawn Md.						24. FUNERAL DIRECTOR Forley-Cranan L.H. Catonsville, Md 25a. REC'D BY REGISTRAR MAR 15 1967 25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items #13 & 14 File #0387 3/27/67 pc									
03134					03125				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Baltimore b. COUNTY Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 2MO		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home					d. STREET ADDRESS 2034 Read Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LULA A. BAILEY					4. DATE OF DEATH Month 3 - Day 25 - Year 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/1881		9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Isiah Bailey					14. MOTHER'S MAIDEN NAME Frances S. Young Kenhart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO NO		17. INFORMANT Address Mrs. Belva I. Tiedemann Same as 2d				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ① Bronchopneumonia 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) ② Chronic Brain Syndrome DUE TO (c) ③ Chronic Urinary tract Infection								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ④ ASCVD ⑤ severe Osteoarthritis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-29- , 19 66 , to 3-25- , 19 67 , that (I) (we) last saw the deceased alive on 3-25- 19 67 , and that death occurred at 11:30 A.M. from causes and on the date stated above.									
22a. SIGNATURE Cesar Valle Cervero					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-25-67		
22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO					22d. ADDRESS 2629 Liberty Rd				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/29/67		23c. NAME OF CEMETERY OR CREMATORY Louden Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR J. I. Stansbury 6411 Windsor Mill Rd.					25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03135					03126					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Balto.</u>					a. STATE <u>Md.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY <u>Balto.</u>					
<u>Bentley Springs</u>					<u>Bentley Springs</u>					
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
-					<u>Bentley Springs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
-					-					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First <u>Howard</u> Middle <u>R. Baker, Jr.</u> Last <u></u>					Month <u>Mar.</u> Day <u>27</u> Year <u>1967</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		
<u>M</u>		<u>W</u>		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		<u>1/28/1918</u>		<u>49</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Steel Fabricator</u>					<u>Steel</u>		<u>Balto. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<u>Howard R. Baker, Sr.</u>					<u>Phillippiance Hoffman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			
<u>Yes</u>					<u>WW II</u>		<u>218-01-1641 Mrs. Janet A. Baker, Bentley Springs, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>										
DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <u></u>										
DUE TO										
(c) <u></u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. <u>19</u>					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<u></u>		<u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 21, 1967</u> , to <u>Mar. 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar. 21, 1967</u> , and that death occurred at <u>11:47</u> M, from the causes and on the date stated above.										
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
<u>C. M. F. France</u>					M.D.		<u>3/30/67</u>			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
<u>A. M. FRANCE</u>					<u>Par. Stn. Rd.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
<u>Burial</u>		<u>3/30/67</u>		<u>New Stablers Cem.</u>		<u>Parkton, Md.</u>				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>J. Jacob Hartenstein, New Freedom, Pa.</u>					APR 3 1967		<u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
03136						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						03127	
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. Howard				c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ft. Howard Hospital						d. STREET ADDRESS 1751 E. Oliver Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ANTONE BARANOSKI						4 DATE OF DEATH Month March Day 12 Year 19 67							
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-8-98		9 AGE (in years lost birthday) 69 yrs		10 IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if ret red.) Shoe Repair				10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair		11 BIRTHPLACE (State or foreign country) Russia				12 CITIZEN OF WHAT COUNTRY USA			
13 FATHER'S NAME Shoe Repair						14 MOTHER'S MAIDEN NAME MARY							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16 SOCIAL SECURITY NO. 220-30 6436		17 INFORMANT JOS. BARANAUSSKAS Address							
18 CAUSE OF DEATH (Enter only one cause per line) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral injury 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO												INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fell on sidewalk									
20c. TIME OF INJURY Month, Day, Year Hour 2 PM 17 19 67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Street				20f. (City or town) (County) (State) Baltimore --- Md.			
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Charles S. Petty				EXAMINER'S NAME (Type) Charles S. Petty				22. DATE SIGNED 3/14/67					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM.				23d. LOCATION (City or town) (County) (State) Ft. Howard, Md.			
24. FUNERAL DIRECTOR T. Fishus - 1930 Eastern Ave.				25a. REC'D BY REGISTRAR APR 16 1967				25b. REGISTRAR'S SIGNATURE Charles J. ...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03137					03128					
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>TOWSON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN ID <u>2 Hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATOR BALTIMORE MEDICAL CEN. PAPER MILL RD. 21131</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Paper Mill Rd. Phoenix, Md.</u> d. STREET ADDRESS <u>PAPER MILL RD. 21131</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Wm. LUTHER</u>		First		Middle		Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1967</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-29</u>		9. AGE (In years last birthday) <u>38</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD. SPEC. WIRE CO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PHOENIX, MD. COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>NEWMON BARRETT</u>					14. MOTHER'S MAIDEN NAME <u>PEARL BYRD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>215-24-5503</u>		17. INFORMANT <u>MRS SADIE P. BARRETT PAPER MILL RD.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4201 Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY</u> (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 27, 1967</u> , to <u>March 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 27, 1967</u> , and that death occurred at <u>2:45-M</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Manuel A. Gongon</u>					M.O. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore County Maryland</u>			
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>					25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

1

2000-01-01

1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03138

CERTIFICATE OF DEATH

03129

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 731 N. Collington Avenue	
3. NAME OF DECEASED (Type or print) First Joseph W. Middle BASE Last BASE		4. DATE OF DEATH Month March Day 3 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-04
9. AGE (In years last birthday) yrs 63		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Postman		10b. KIND OF BUSINESS OR INDUSTRY U.S. mail	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK J. BASE		14. MOTHER'S MAIDEN NAME Rose Stredcek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 216-44-3418	
17. INFORMANT Mary F. Base		Address 731 N. Collington Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the colon DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1058			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) February		20f. (City or town) (County) (State) Baltimore	
21. I certify that (I) (this hospital) attended the deceased from February 29, 1967 to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 8:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Eduardo M. Canilang M.D.		22b. DATE SIGNED 3-3-67	
22c. PHYSICIAN'S NAME (Type) Eduardo M. Canilang MD.		22d. ADDRESS 7620 York Road, Baltimore 21204 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-7-67	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Philip E. Czech		25a. REC'D BY REGISTRAR 1211 Chosaco Ave.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 7 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL CEMETERY: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03139 CERTIFICATE OF DEATH 03130

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville c. LENGTH OF STAY IN b unk. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miller Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Ba 40 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 535 Carey Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY HERNDON BASKERVILLE		4. DATE OF DEATH Month 8 Day 13 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 13	11. IF UNDER 24 HRS. Hours 13 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTH-PLACE (County & State, or foreign country) OXFORD, NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DRURY HERNDON		14. MOTHER'S MAIDEN NAME SALLIE PATTERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT Dr. Mary N. Brooks		Address 535 N. Carey Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Central Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertensive Cardiac Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unk.		INTERVAL BETWEEN ONSET AND DEATH 2 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-15-1967 to 3-15-1967 , that (I) (we) last saw the deceased alive on 3-12-1967 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE Richard H. Hunt		22b. DATE SIGNED 3-15-67	
22c. PHYSICIAN'S NAME (Type) Richard H. Hunt		22d. ADDRESS 1607 Mulberry St Balto. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-16-67	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	23d. LOCATION (City, town or county) (State) Arbutus, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Morton & Dyett F.H.		25a. REC'D BY REGISTRAR 15 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03140

CERTIFICATE OF DEATH

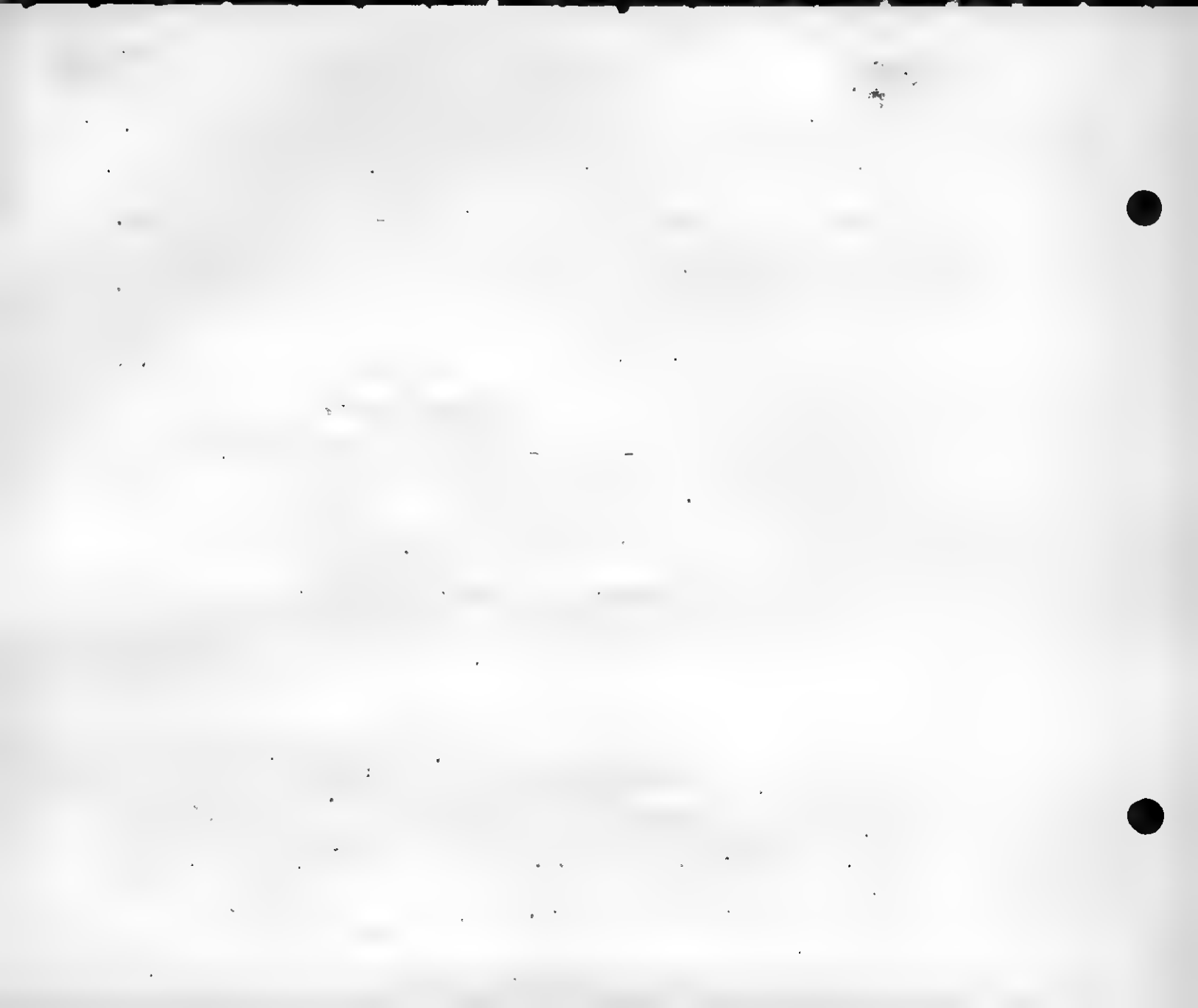
03131

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN IS 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 2617 WILKINS AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last VINCENT DE PAUL BEATTY				4 DATE OF DEATH Month Day Year MARCH 31 19 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEBRUARY 5, 1901	9 AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY <i>Super Dept. Delivery</i>		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME WILLIAM LEO BEATTY				14. MOTHER'S MAIDEN NAME MARY MC CALL			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16 SOCIAL SECURITY NO 216 07 49 78		17 INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DISORDER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA WITH METASTASIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from MARCH 23 , 19 67 , to MARCH 31 , 1967, that (1) (we) last saw the deceased alive on MARCH 31 , 19 67 , and that death occurred at 3:40 A M, from causes and on the date stated above.							
22a SIGNATURE <i>Peter W. Juvan</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) PETER W. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 4/13/67		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24 FUNERAL DIRECTOR <i>Cowan</i>				ADDRESS COWAN FUNERAL HOME		25a REC'D BY REGISTRAR APR 3 1967	
						25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
901 Hollins St. Baltimore, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
0314: 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN IB <u>27yr5mth17dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					03132 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk, Maryland</u> d. STREET ADDRESS <u>Route 3- Box 44 -Holabird Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mathias</u> Middle <u>Bedrunka</u> Last <u>Bedrunka</u>			4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1967</u>								
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 15, 1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>brewery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Mathaus Bedrunka</u>					14. MOTHER'S MAIDEN NAME <u>Theresa Freisler</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-01-4455-A</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, severe</u> DUE TO (c) <u>Parkinsonism - Systolic hypertension</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that the (this hospital) attended the deceased from <u>Sept. 25, 1939</u> to <u>March 12, 1967</u> , that we (we) last saw the deceased alive on <u>March 12, 1967</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Anthony J. Young, M.D.</u>						22b. DATE SIGNED <u>3-13-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u>						22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. John's Cem</u>		23d. LOCATION (City, town or county) (State) <u>HOWARD Co. Md.</u>					
24. FUNERAL DIRECTOR <u>E. S. MacNabb</u> ADDRESS <u>301 Frederick Rd</u> <u>Balt 28 Md</u>						25a. REG'D. BY REGISTRAR <u>MAR 20 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

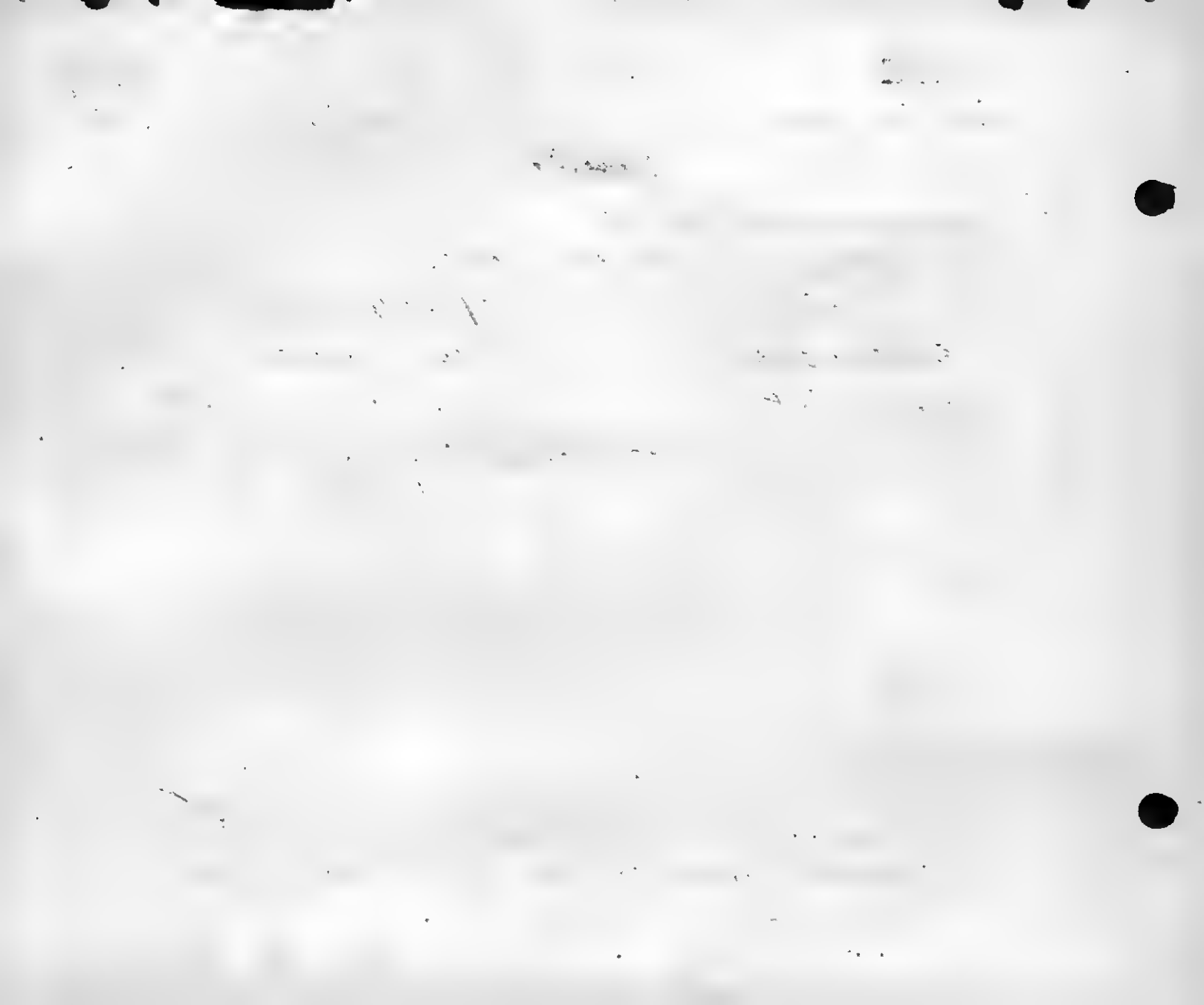


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Now~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03142		03133	
1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 580 Frederick Rd	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS Baltimore 28	
3. NAME OF DECEASED (Type or print) PAUL FOSTER BELL		4. DATE OF DEATH Month 3 Day 4 Year 1967	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/27/14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William H. BELL		14. MOTHER'S MAIDEN NAME VIRGINIA CARL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no), or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 42-01-248	
17. INFORMANT Mrs. Francis Kearney-580 Frederick Rd. Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, PULMONARY 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/24 , 19 66 to 3-4 , 19 67 , that (I) (we) last saw the deceased alive on 3-4-67 , and that death occurred at 1:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer, M.D., Superintendent		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-7-67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave.		25a. REC'D BY REGISTRAR MAR 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



03143

CERTIFICATE OF DEATH

03134

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>			c. LENGTH OF STAY IN 1b <u>3yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>524 Stevenson Lane</u>				d. STREET ADDRESS <u>524 Stevenson Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence Lee Bennett</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/15/17</u>	
9. AGE (In years last birthday) <u>49</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Fred H. Waters</u>				14. MOTHER'S MAIDEN NAME <u>Ada Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Arthur Bennett</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration & Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Undifferentiated Carcinoma origin</u> DUE TO (c) <u>undetermined</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>Mar 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Mar 10</u> 19 <u>67</u> , and that death occurred at <u>12:45 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Th. Ferriot</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas N. Ferriot III</u>				22d. ADDRESS <u>2045 York Rd Timonium</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY MEA</u>		23d. LOCATION (City or Town) (County) (State) <u>COCKEYSVILLE MD.</u>	
24. FUNERAL DIRECTOR <u>JOHN BURNS Sons</u>				ADDRESS <u>Towson</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03144

CERTIFICATE OF DEATH

03135

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY KENT ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 11 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL				d STREET ADDRESS		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First RUTH Middle C. Last BENNETT				4 DATE OF DEATH Month MARCH Day 17 Year 19 67			
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APRIL 4, 1894		9 AGE (In years last birthday) yrs 72	10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10b KIND OF BUSINESS OR INDUSTRY NURSING		11 BIRTHPLACE (County & State, or foreign country) HAVERHILL, MASS.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JAMES CASWELL				14. MOTHER'S MAIDEN NAME BERTHA LARRAWAY			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16 SOCIAL SECURITY NO 214 22 31 42		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE. DIABETES MELLITUS						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour 'a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from 3/6/67 , 19__, to 3/17/67 , 19__, that (1) (we) last saw the deceased alive on 3/17/67 , 19__, and that death occurred at __ M, from causes on and on the date stated above							
22a SIGNATURE <i>George Dudas</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d. ADDRESS VAH FORT HOWARD, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/20/67		23c NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d LOCATION (City or Town) (County) (State) near - Chestertown, Md.	
24. FUNERAL DIRECTOR <i>J. Willis Wells</i>				ADDRESS J. WILLIS WELLS FUNERAL HOME		25a REC'D BY REGISTRAR DATE MAR 20 1967	
				25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

415

03145

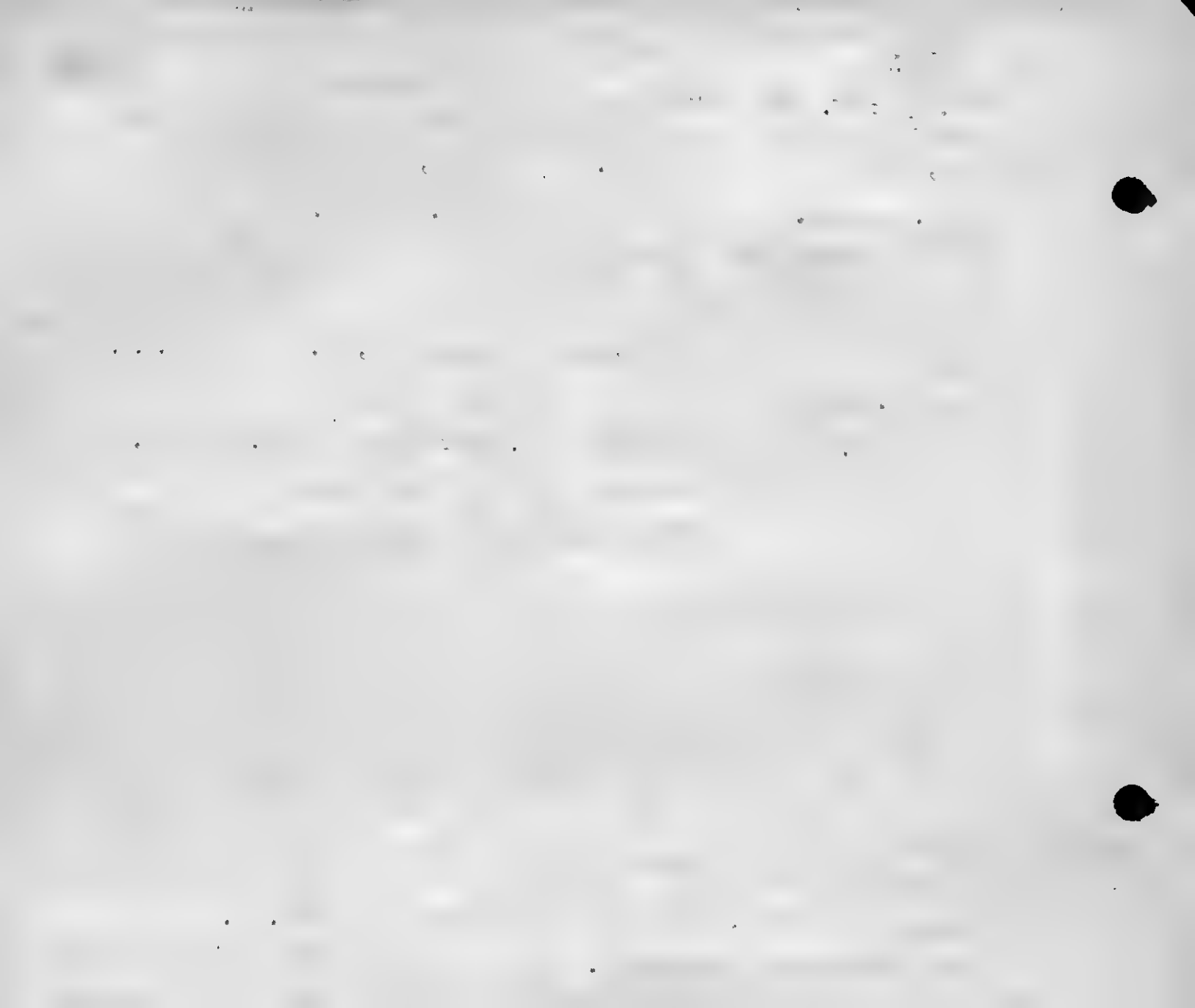
CERTIFICATE OF DEATH

03136

1. PLACE OF DEATH COUNTY <u>Joppa</u> <u>Rd.</u> <u>Hampton House Apt 1014</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Towson</u>	
c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>		d. STREET ADDRESS <u>204 E. Joppa Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>204 E. Joppa Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Hayes Benson</u>		4. DATE OF DEATH Last First Middle <u>March 22 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cockeysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josuha E. Benson</u>		14. MOTHER'S MAIDEN NAME <u>Katie Hayes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW. I II</u>		16. SOCIAL SECURITY NO. <u>220 46 5358</u>	
17. INFORMANT <u>Mrs. Edward Benson</u>		Address <u>204 E. Joppa Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause primary for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery occlusion</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3/22/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from..... 12..... to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Hamed, MD</u>		22b. DATE SIGNED <u>3/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED MD</u>		22d. ADDRESS <u>204 E. JOPPA RD TOWSON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jessups Cockeysville</u>	23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03146

03137

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hibbatus</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1230 North Ave</u>				d. STREET ADDRESS <u>1230 North Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Mildred K. Berger</u>				4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/28/09</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry F. Blankner</u>				14. MOTHER'S MAIDEN NAME <u>Frieda Berger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>21-20-1267</u>		17. INFORMANT <u>George H. Berger</u> Address <u>1230 North Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Debate Meditatio</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 7</u> , 19 <u>67</u> , to <u>March 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 7</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>John C. Healey</u>				22b. DATE SIGNED <u>3/30/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. John Healey</u>	
22d. ADDRESS <u>1311 Franklin Ave.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 30</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Amberose Inc 1308 Sulphur Sp Rd</u>				25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

03147

CERTIFICATE OF DEATH

03138

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4218 Kensington Road		d. STREET ADDRESS 4218 Kensington Road	
3 NAME OF DECEASED (Type or print) John J. Biemiller, Sr.		4 DATE OF DEATH Month March Day 16 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-26-1902
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) yrs. 65
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Edward Biemiller		14. MOTHER'S MAIDEN NAME Elizabeth Jordan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 216-03-8715	17. INFORMANT Anna M. Biemiller, 4218 Kensington Road
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC CV Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12, 1936 to 3/16, 1967 , that (I) (we) last saw the deceased alive on 3/15, 1967 , and that death occurred at 3:41 M, from causes and on the date stated above			
22a. SIGNATURE <i>Dr. Thomas E. Roach</i>		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas E. Roach		22d. ADDRESS 5550 Baltimore National Pike, Balto., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3-20-1967	23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore County, Maryland
24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		25a REC'D BY REGISTRAR 21229	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03148

CERTIFICATE OF DEATH

03139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 1365 Salem Ave	
3. NAME OF DECEASED (Type or print) First Percy Middle Kritzman Last Blain		4. DATE OF DEATH Month 3 Day 21 Year 1967	
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-2-1890
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 3 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Wood	
11. BIRTHPLACE (County & State, or foreign country) md. (Wash. Co.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Blain		14. MOTHER'S MAIDEN NAME Alice Tostler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 170-12-7889	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CO21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 26, 1965 , to March 21, 1967 , that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 7 p.m. from causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 3.21.67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/25/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. D.C.
24. FUNERAL DIRECTOR Robert M. Martin		25. REC'D BY REGISTRAR MAR 27 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

9

1



03149

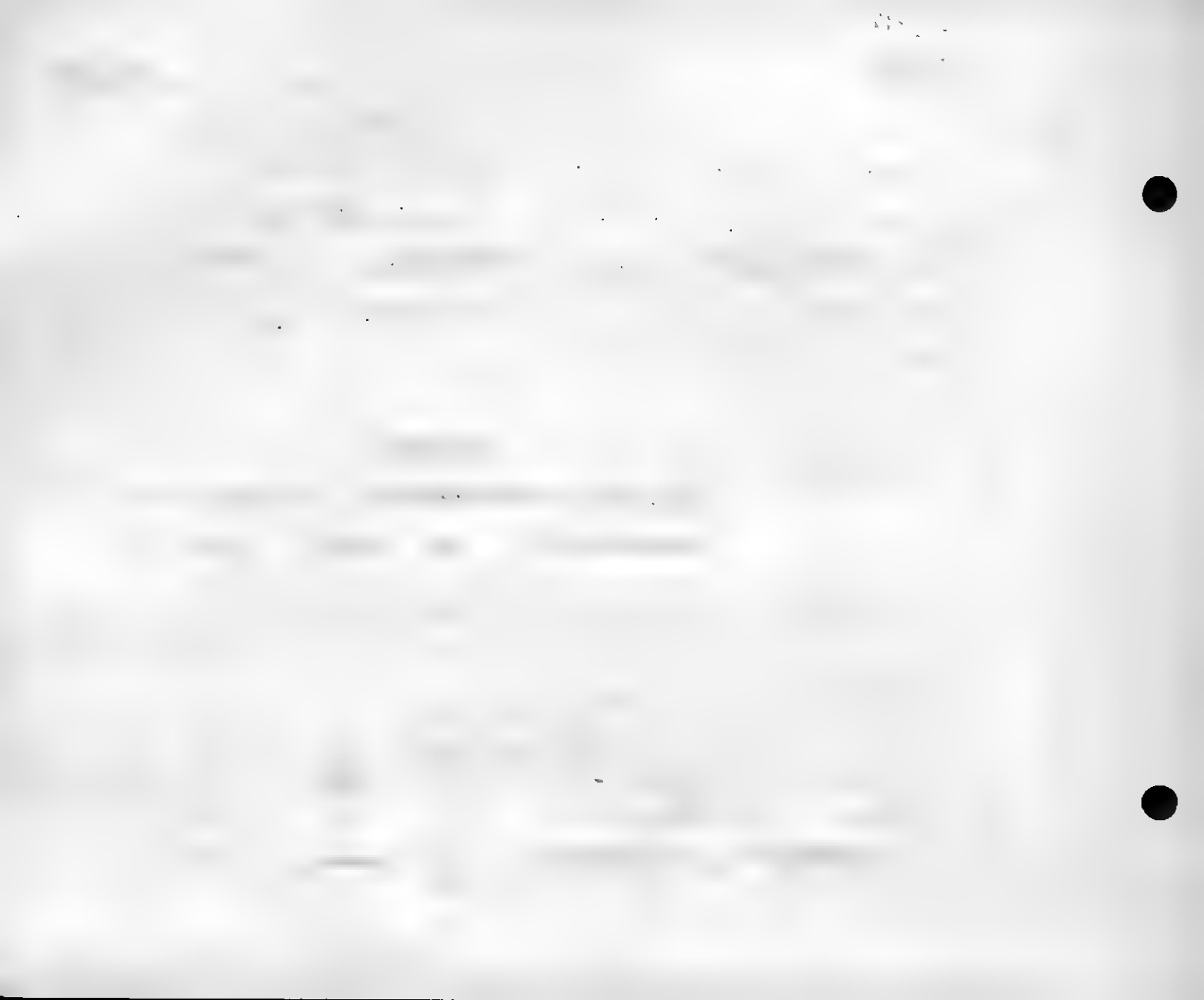
CERTIFICATE OF DEATH

03140

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSP.</u>		d. STREET ADDRESS <u>7239 PARK HEIGHTS AVE.</u>	
3 NAME OF DECEASED (Type or print) <u>ABRAHAM BOGART BOGART</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	9. AGE (In years last birthday) <u>68</u> yrs
13. FATHER'S NAME <u>Simon</u>		14. MOTHER'S MAIDEN NAME <u>ANNY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>051-07-0759</u>	17. INFORMANT <u>CHART</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERY DISEASE</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>67</u> to <u>3/19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>67</u> , and that death occurred at <u>3:40</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Mariano A. Tolentino</u> M.D.		22b. DATE SIGNED <u>3/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARIANO A. TOLENTINO</u>		22d. ADDRESS <u>5731 SIMMONDS AVE., BALTIMORE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/21/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HAR SINAI</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>
24. FUNERAL DIRECTOR <u>SYLVAN S. LEWIS & SON, INC. - BARRISON, MD</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03150

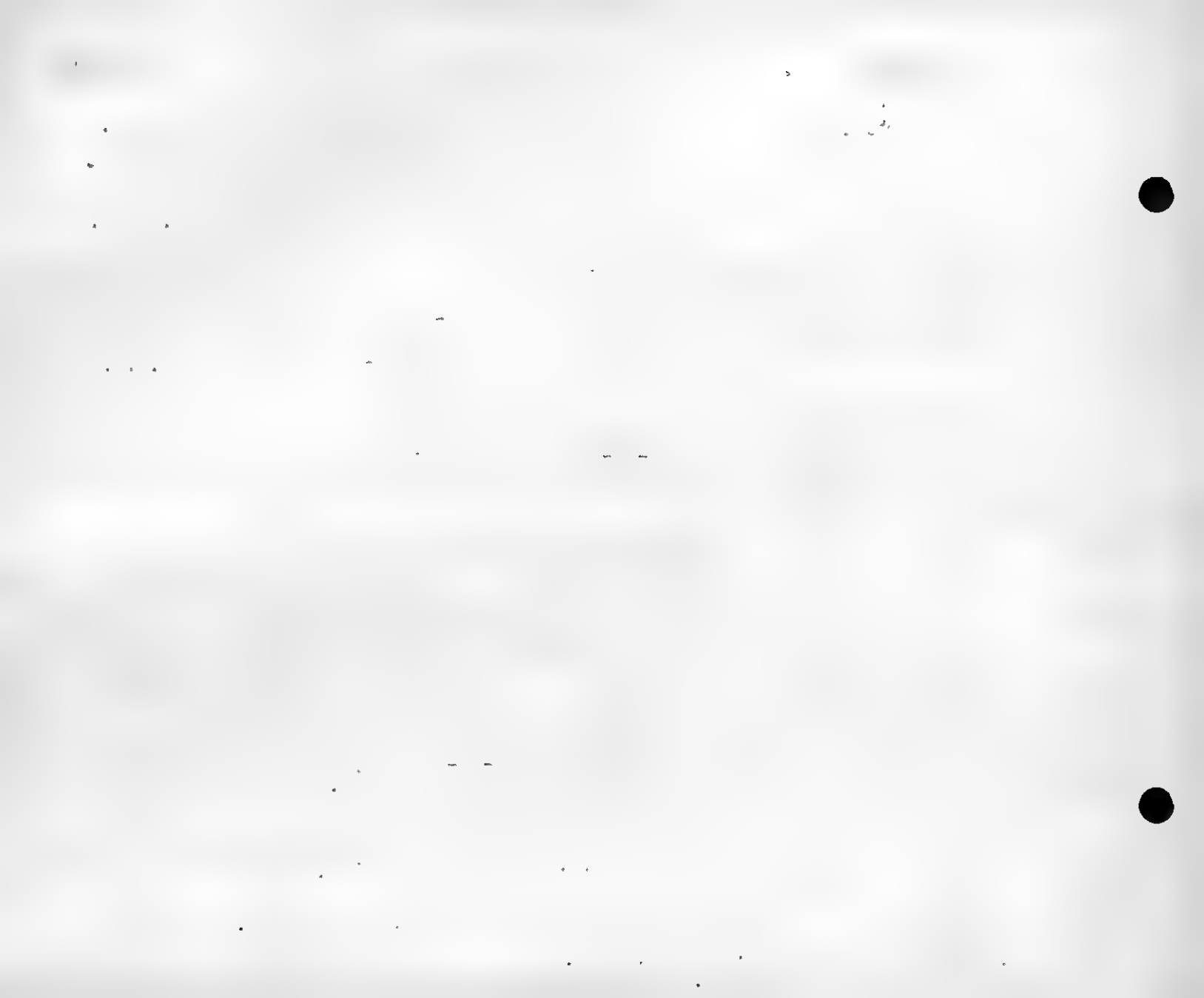
CERTIFICATE OF DEATH

03141

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 5mth23dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Maryland d. STREET ADDRESS 308 Regester Avenue Balto., Md. e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input type="checkbox"/> YES			
3 NAME OF DECEASED (Type or print) Philomena S. Bohn First Middle Last 5 SEX Female 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH 1-10-84 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9 AGE (In years last birthday) 83 10 UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>				11 BIRTHPLACE (County & State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.A. 13 FATHER'S NAME William 14 MOTHER'S MAIDEN NAME Theresa 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16 SOCIAL SECURITY NO 218-30-6189 17 INFORMANT Records: Spring Grove State Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Hypostatic pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				INTERVAL BETWEEN ONSET AND DEATH 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome				20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 9-15-66 , to March 8, 1967 , that (s) (we) last saw the deceased alive on March 8, 1967 , and that death occurred at 1:10 P.M. , from causes and on the date stated above.				22a SIGNATURE <i>Evelio A. Felipe</i> M.D. 22b. DATE SIGNED 3-8-67 22c PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D. 22d ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial 23b DATE THEREOF 3/11/67 23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. 23d LOCATION (City or Town) (County) (State) Balto.				24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 25a REC'D BY REGISTRAR DATE AR 15 1967 25b REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03151

CERTIFICATE OF DEATH

03142

1. PLACE OF DEATH a. COUNTY <i>Balto</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Balto</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2620 Hillcrest</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Balto</i> d. STREET ADDRESS <i>2620 Hillcrest</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SOPHIA M. BRANDT</i> First Middle Last 4. DATE OF DEATH <i>March 5, 1967</i> Month Day Year		5. SEX <i>F</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>12/11/1919</i> 9. AGE (In years last birthday) <i>47</i> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore</i> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Henry Hecker</i> 14. MOTHER'S MAIDEN NAME <i>Catharine Weisbrod</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> 16. SOCIAL SECURITY NO. <i>no</i> 17. INFORMANT <i>Daughter</i> Address <i>same</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO (b) <i>4 hrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <i>10 Sept</i> , 19 <i>66</i> , to <i>5 March</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4 March</i> 19 <i>67</i> , and that death occurred at <i>12 M</i> , from the causes and on the date stated above. 22a. SIGNATURE <i>Howard Elbaum</i> 22b. DATE SIGNED <i>6 March 67</i> 22c. PHYSICIAN'S NAME (Type) <i>Howard Elbaum</i> 22d. ADDRESS <i>6604 Harford Rd Balto Md 21234</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>3/7, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Immortal</i> 23d. LOCATION (City, town or county) (State) <i>Balto Md</i>		24. FUNERAL DIRECTOR <i>Adelmann 6667 Hay Rd</i> ADDRESS 25a. REC'D BY REGISTRAR <i>MAR 9 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03152

03143

1. PLACE OF DEATH a. COUNTY <i>Balti.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balti.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown, Md.</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown, Md.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Balti. Co. Gen. Hosp.</i>				d. STREET ADDRESS <i>3511 Fox Cliff Ct.</i>			
3. NAME OF DECEASED (Type or print) First <i>IDA</i> Middle <i>BRILLIANT</i> Last S. SEX <i>Female</i> 6. COLOR OR RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Sept 22 1894</i> 9. AGE (In years, last birthday) <i>72</i> yrs. IF UNDER 1 YEAR Months Days Hours Min				4. DATE OF DEATH <i>Mar 18 1967</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Balti. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Abraham C. Levitsky</i>				14. MOTHER'S MAIDEN NAME <i>Clara Elhart</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-52-1199T</i>		17. INFORMANT <i>Balti. Co. Gen. Hosp. Records.</i>		Address <i>Randallstown Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>11201</i> IMMEDIATE CAUSE (a) <i>sudden myocardial infarction</i> DUE TO (b) <i>Arteriosclerotic C-V. Disease</i> DUE TO (c) <i>1 yr.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>None</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D. D. Caples</i> M.D.				22. DATE SIGNED <i>3-18-1967</i>			
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/19/1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Herring Run</i>		23d. LOCATION (City or town) (County) (State) <i>Balti. Md.</i>	
24. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son, Inc.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

03153

03144

1 PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 - 7 Mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women + Aged Men Home</u>		d. STREET ADDRESS <u>307 W. Fagnole St</u>	
3. NAME OF DECEASED (Type or print) <u>Bertha Brinkley</u>		4. DATE OF DEATH <u>Mar 18 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 15 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Hall Brinkley</u>		14. MOTHER'S MAIDEN NAME <u>Lena Guise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-18-5715</u>	
17. INFORMANT <u>A. Marie Weaver R.N.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (b) <u>Bronchial pneumonia</u> DUE TO (c) <u>Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>2 weeks</u> <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 8 1962</u> to <u>March 18 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18 1967</u> , and that death occurred at <u>8:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland Edmund Day</u>		22b. DATE SIGNED <u>3-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland Edmund Day M.D.</u>		22d. ADDRESS <u>4-E-33rd St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-1967</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Louisa Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Will Cook Brooks-Townson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1050 York Rd Towson Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAR 22 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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SHIPPED TO: WHEELER & THOMPSON FUNERAL HOME, FREDERICKSBURG, VIRGINIA

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03154

CERTIFICATE OF DEATH

03145/

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN Id 48 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 107 PATAPSCO AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d. STREET ADDRESS BALTIMORE, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last EVERETT R. BROOKS			4. DATE OF DEATH Month Day Year MARCH 13 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/14	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months Days Hours Min 13 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) BROKENBURG, VA.	
13. FATHER'S NAME JOHN SAMUEL BROOKS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES WW II			16. SOCIAL SECURITY NO 218 07 62 08		
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			Address		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LUNG ABSCESS, RIGHT, UNDETERMINED ORGANISM DUE TO Candid ons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA TO BONES, BRAIN, LIVER DUE TO (c) BRONCHOGENIC CARCINOMA, RIGHT					INTERVAL BETWEEN ONSET AND DEATH DAYS MONTHS MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (a) (this hospital) attended the deceased from 1/24/67 , 19__, to 3/13/67 19__, that (I) (we) last saw the deceased alive on 3/13/67 19__, and that death occurred at 9:55A M, from causes and on the date stated above					
22a. SIGNATURE <i>Neilson Neilson</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/13/67
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.			22d. ADDRESS VAH FORT HOWARD, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Type) REMOVED		23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY GOOD HOPE CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) SPOTSYLVANIA, VIRGINIA
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>			25a. REC'D BY REGISTRAR JOSEPH N. ZANNINO		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
			25c. DATE APR 20 1967		
			25d. ADDRESS 257 S. CONKLING ST. BALTIMORE, MD.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03155 CERTIFICATE OF DEATH 03146

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catochsville c. LENGTH OF STAY IN 1b 11yr8mth17dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2638 Dulaney Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alberta Middle M. Last Brown			4. DATE OF DEATH Month 3 Day 5 Year 19 67				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1890	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KING OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) Maryland			
13. FATHER'S NAME Theodore Laydecker			12. CITIZEN OF WHAT COUNTRY? U. S.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. 219-01-5593				
17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage days 331A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis years DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NONE			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from June 11 , 19 55 , to March 5 , 19 67 , that (I) (we) last saw the deceased alive on March 5 , 19 67 , and that death occurred at 6:45 A.M., from the causes and on the date stated above.				
22a. SIGNATURE George A. Roden			22b. DATE SIGNED 3-5-67				
22c. PHYSICIAN'S NAME (Type) George A. Roden			22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Sater's			
23d. LOCATION (City, town or county) (State) Baltimore, Co. Md.		24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202					
25a. REC'D BY REGISTRAR MAR 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					



03156

CERTIFICATE OF DEATH

03147

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>3 month</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>202 Winters Lane</u> <u>3117 HUNTER HILL AVE</u>	
3 NAME OF DECEASED (Type or print) <u>Marshall</u> First <u>Brown</u> Middle Last		4 DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/6/1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>67</u> yrs.
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Brown</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rollins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT <u>Dorothy Brown - 202 Winters Lane</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia (Aspiration)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Semi Coma</u> DUE TO (c) <u>CVA in Rt. side Hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Epileptic Seizures due to CVA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-19-1967</u> , to <u>3-24-1967</u> , that (I) (we) last saw the deceased alive on <u>3-24-1967</u> , and that death occurred at <u>8:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Cervero</u>		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>		22d. ADDRESS <u>8629 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 27 1967</u>	

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VR A15 (4)
20 M 1/66

03157

CERTIFICATE OF DEATH

03148

1 PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Catonsville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b <u>1 Year</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATON RIDGE NURSING HOME</u>		d. STREET ADDRESS <u>317 Mason Court</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Philip Cross (Budzynski)</u>	4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1967</u>	5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 8, 1887</u> 9. AGE (In years last birthday) yrs <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	10b. KIND OF BUSINESS OR IND. STRY <u>Moulder</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>—</u>
13. FATHER'S NAME <u>Henry Budzynski</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Novakowski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Sept 19, 17</u>	16. SOCIAL SECURITY NO <u>215-09-0394</u>	17. INFORMANT Address <u>Edward Miller 4214 Sheldon Ave.</u>	
18. CAUSE OF DEATH (Give only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF HEAD OF PANCREAS</u> DUE TO <u>7X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>GENERALIZED METASTASES</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-10-</u> , 19 <u>66</u> , to <u>3-5-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-5-</u> , 19 <u>67</u> , and that death occurred at <u>11 A</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Cavero</u>		22b. DATE SIGNED <u>3-5-67</u>	22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERO</u>
22d. ADDRESS <u>8629 Liberty Rd</u>		22e. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-8-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc.</u>		25. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

03158

CERTIFICATE OF DEATH

03149

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>627 WASHINGTON AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>C.</u> Last <u>BULL</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1882</u>
9. AGE (In years last birthday) <u>84 yrs</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CORNELIUS SCHULTE</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>HOWARD B. STOCKSDALE-2E-LEXINGTON ST. MD.</u>		Address <u>ZONE-2 BALTO</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCHARDIAL INFARTION</u> <u>4201</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>YEARS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-9, 1954</u> , to <u>3-24, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-24, 1967</u> , and that death occurred at <u>8:30 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Rolando G. Vieta</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO G. VIETA</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD.</u>
24. FUNERAL DIRECTOR <u>Frank A. Senty 814 W. 36th St. Balto Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03159

03150

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

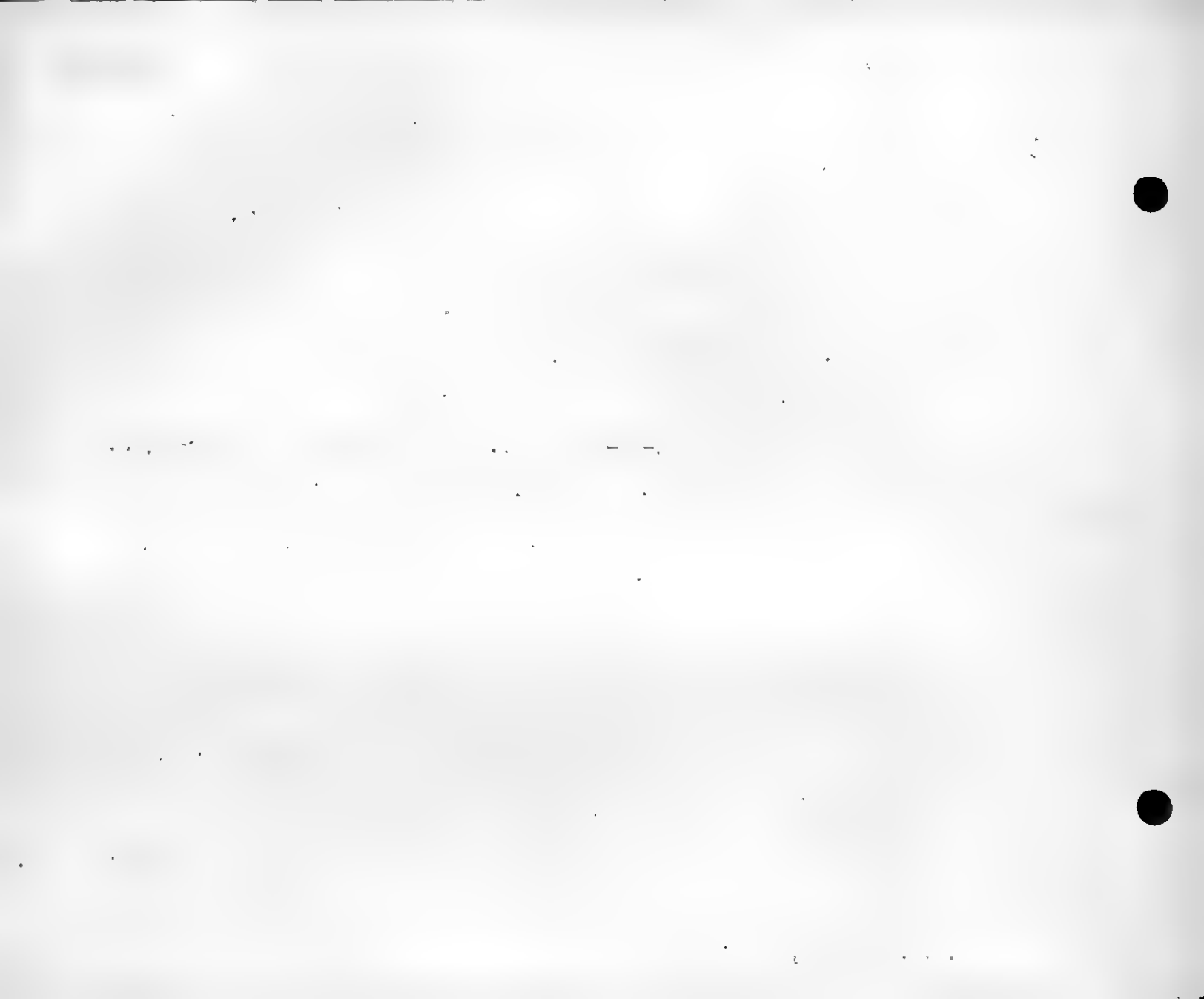
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY BALTIMORE, MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE NEW JERSEY b COUNTY CAMDEN	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ATCO (N.J.)		c LENGTH OF STAY IN IL 2 1/2 yrs	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d STREET ADDRESS 137 JACKSON RD (ATCO N.J.)	
3 NAME OF DECEASED (Type or print) JOHN EDWARD BURCHELL		4 DATE OF DEATH MARCH 31 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-12-21 (45 yrs)
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR - GRAYMOUND CORP.		10b KIND OF BUSINESS OR INDUSTRY PENNA.	
13. FATHER'S NAME JOHN BURCHELL		14. MOTHER'S MAIDEN NAME SEVILLA CAMPBELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW2		16. SOCIAL SECURITY NO. 171-14-9564	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, need an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher M.D.		22 DATE SIGNED 4-1-67	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b DATE THEREOF 4-5-67	23c NAME OF CEMETERY OR CREMATORY ATCO Cem.	23d LOCATION (City or Town) (County) (State) ATCO N.J.
24 FUNERAL DIRECTOR Wm F. Woods		25a REC'D BY REGISTRAR APR 3 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>03160</p> </div> <div> <p>DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>03151</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>179 Baltimore Ave</u>					d. STREET ADDRESS <u>179 Baltimore Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>EDWARD</u> Last <u>BURGESS</u>					4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 7, 1898</u>		9. AGE (in years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Highway Dept.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore County</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Howard County, Md</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Burgess</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Harrison</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-22-5986</u>		17. INFORMANT Address <u>Mrs. Ruth Burgess, 179 Baltimore Ave.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 74001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Vascular Disease</u> DUE TO (c) <u>Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 yr</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2, 1967</u> , to <u>Mar 21, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>Mar 19, 1967</u> , and that death occurred at <u>2:25</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>B B Brumbaugh</u> M.D.								22b. DATE SIGNED <u>3/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>					22d. ADDRESS <u>5609 Waverly St Edgemoor 27 Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-24-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>			23d. LOCATION (City, town or county) (State) <u>Ellicott City, Md</u>		
24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md</u>					25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>				
					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

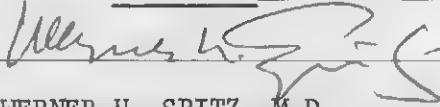
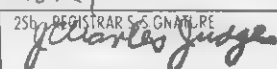


FOR STATE
HEALTH DEPT.

03161

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03152

1 PLACE OF DEATH a. CITY OR TOWN Baltimore b. COUNTY Maryland		2 USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rosedale		c. LENGTH OF STAY IN 1b 40 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 370 Choptank Avenue		e. STREET ADDRESS 370 Choptank Avenue	
3 NAME OF DECEASED (Type or print) GEORGE T. (BURKHART) BURKHART		4 DATE OF DEATH Month 3 Day 6 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 6, 1901
9 AGE (In years last birthday) 66 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
10b. KIND OF BUSINESS OR INDUSTRY Const. Co		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Paul Burkhardt	
14. MOTHER'S MAIDEN NAME Josephine Burkhauser		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Manue B. Cotter Address 16 Manchella Ave Coral Gables, Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		22. DATE SIGNED 3-6-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-9-67	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR Philip E. Crach ADDRESS 1211 Chesaco Ave.		25a. RECEIVED BY REGISTRAR MAR 9 1967	
		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03162

CERTIFICATE OF DEATH

03153

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b days		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 408 South Gilmore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Everett Middle P. Last Burns		4. DATE OF DEATH Month March Day 3 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1888 9. AGE (In years last birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Basil R. Burns		14. MOTHER'S MAIDEN NAME Alvina Brandenburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 213-09-8318		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the Lung 100X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 28, 1967 to 3/3, 1967 , that (I) (we) last saw the deceased alive on 3/3/67 , and that death occurred at 11:30 P.M. causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-7-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) 3801 Frederick Ave. 21229
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE 21229 MAR 6 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Copyright

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03163

CERTIFICATE OF DEATH

03154

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS 3315 E. Joppa Rd.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3315 E. Joppa Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Aquilla F. Burton Sr.				4. DATE OF DEATH Month March Day 5 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 23 1879		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Burton				14. MOTHER'S MAIDEN NAME Mary Kirkendall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-6164		17. INFORMANT Address Family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH Unat.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-27 , 19 65 , to 3-5 , 19 67 , that (II) (we) last saw the deceased alive on 20 Jan 19 67 , and that death occurred at 1:40 M, from the causes and on the date stated above.							
22a. SIGNATURE John C. Hyle				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) JOHN C. HYLE MD				22d. ADDRESS 7527 Belair Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem		23d. LOCATION (City, town or county) (State) Balto Co Md	
24. FUNERAL DIRECTOR C.F. EVANS & SON				ADDRESS 8802 Harford rd.		25a. REC'D BY REGISTRAR MAR 10 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20 M 1/66

03164

CERTIFICATE OF DEATH

03155

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Res dence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyde			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS Bottom Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Martin Byrne				4. DATE OF DEATH Month March Day 20 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-86	9. AGE (In years last birthday) yrs 80	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lloyd E. Mitchell & Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK Byrne				14. MOTHER'S MAIDEN NAME SALLY Kidd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-8343		17. INFORMANT Thomas C. Byrne		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured abdominal aneurysm 401A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20th 19 67 pm March 20, 19 67 that (I) (we) last saw the deceased alive on March 20th 19 67 , and that death occurred at 11:20 PM , from causes and on the date stated above.							
22a. SIGNATURE Melencio Ventura				22b. DATE SIGNED March 20, 1967		22c. PHYSICIAN'S NAME (Type) Melencio Ventura M.D.	
22d. ADDRESS 7620 York Road, Towson 21204, Md.				22e. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-24-1967		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City or town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR Chas. T. Evanson				25a. REC'D BY REGISTRAR MAR 22 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

03165

CERTIFICATE OF DEATH

03156

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1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mifflord Manor Nursing Home</u>		d. STREET ADDRESS <u>3303 Dorthon Road</u>	
3. NAME OF DECEASED (Type or print) <u>Rebecca</u> <u>Caplan</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15, 1873</u>
9. AGE (In years last birthday) <u>94</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13. FATHER'S NAME <u>Morris Sandler</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>257-03-2286A</u>	
17. INFORMANT <u>Mrs Ben Masaryk</u>		Address <u>419 Upland Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: <u>357X</u> IMMEDIATE CAUSE (a) <u>Cerebral Vascular Cerebroclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>47 hr</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1958</u> to <u>MAR 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR 8, 1967</u> , and that death occurred at <u>4:15</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Albert J. Himelefarb</u>		22b. DATE SIGNED <u>3/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert J. Himelefarb</u>		22d. ADDRESS <u>3501 ST. PAUL ST. BALTIMORE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>March 10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bonaventure</u>	23d. LOCATION (City or town) (County) (State) <u>Savannah Georgia</u>
24. FUNERAL DIRECTOR <u>Sol Lennson & Sons</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	
ADDRESS <u>6010 Reisterstown Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03166					03157								
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)								
a. COUNTY		Baltimore			a. STATE		b. COUNTY						
		MARYLAND			Maryland		Baltimore						
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
Reisterstown		2 1/2 years			Reisterstown								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
1 Reisterstown Road					1 Reisterstown Rd.								
3. NAME OF DECEASED (Type or print)		First		Middle	Last	4. DATE OF DEATH		Month	Day	Year			
Edna		Marcell		Caples	March		21		1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 16, 1907		60 yrs.		Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housewife		---		Georgia		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Copeland		Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
No		212-36-8977		Mr. V. Talbott Caples		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis of liver							
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
						20c. TIME OF INJURY Month, Day, Year							
						20d. INJURY OCCURRED							
						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
						20f. (City or town) (County) (State)							
						21. I certify that (I) (the deceased) attended the deceased from 3-3-54, 19....., to 3-21-67, 19....., that (I) (we) last saw the deceased alive on 3-20-67, 19....., and that death occurred at 7 A M, from the causes and on the date stated above.							
						22a. SIGNATURE							
						22b. DATE SIGNED							
						22c. PHYSICIAN'S NAME (Type)							
						22d. ADDRESS							
						23a. BURIAL, CREMATION, REMOVAL (Specify)							
						23b. DATE THEREOF							
						23c. NAME OF CEMETERY OR CREMATORY							
						23d. LOCATION (City, town or county) (State)							
						24. FUNERAL DIRECTOR'S SIGNATURE							
						25a. REC'D BY REGISTRAR							
						25b. REGISTRAR'S SIGNATURE							

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03167

CERTIFICATE OF DEATH

03158

1 PLACE OF DEATH a. COUNTY BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 80 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 1042 N. STRICKER STREET	
3 NAME OF DECEASED (Type or print) First GROVER Middle C. Last CAREY		4 DATE OF DEATH Month MARCH Day 1 Year 67	
5 SEX MALE	6. COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH FEB. 14. 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	9. AGE (In years lost birthday) yrs 45
11 BIRTHPLACE (County & State, or foreign country) LOTTSBURG, VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JAMES CAREY		14. MOTHER'S MAIDEN NAME JULIA SAMUEL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II		16 SOCIAL SECURITY NO 227 14 03 36	
17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT LUNG WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost RIGHT LOBAR PNEUMONIA (c) PULMONARY CONGESTION AND EDEMA			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT RECENT
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 12/12/66 , 19 to 3/1/66 , 19, that (X) (we) last saw the deceased alive on 3/1/66 , 19, and that death occurred at 7:15 PM from causes and on the date stated above			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR <i>Vernon R. Bailey</i>		25a. REC'D BY REGISTRAR MAR 6 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03168

CERTIFICATE OF DEATH

03159

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS Rt. 1 - Box 152				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gale		First Charlene		Middle CHAPMAN		Last		4. DATE OF DEATH Month 3 Day 2 Year 19 67	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-5-60		9. AGE (In years last birthday) 6 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Alfred Chapman, Jr.				14. MOTHER'S MAIDEN NAME Effie Irene Turner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral insufficiency DUE TO (c) Interval Hydrocephalus				INTERVAL BETWEEN ONSET AND DEATH Terminal Terminal 6 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 1-20 , 19 65 , to 3-2 , 19 67 , that if (we) last saw the deceased alive on 3-2 , 19 67 , and that death occurred at 1:30 Mar 67 from causes and on the date stated above.									
22a. SIGNATURE Richard A. Jones				22b. DATE SIGNED 3 Mar 67		22c. PHYSICIAN'S NAME (Type) Richard A. Jones			
22d. ADDRESS Rosewood State Hosp									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-67		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d. LOCATION (City or Town) (County) (State) BRYANTOWN Md.			
24. FUNERAL DIRECTOR Geo. J. Kierulff				ADDRESS 1341 N. ...		25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTO.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO				c. LENGTH OF STAY IN 1b 42 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTO				d. STREET ADDRESS 4301 PARKWAY ST. W. 2127A	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater BALTO MED. Center.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Holger Christensen			4. DATE OF DEATH Month March Day 14 Year 1967			5. SEX M			6. COLOR OR RACE W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2/25/1890			9. AGE (In years last birthday) 77 yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.N.K.			10b. KIND OF BUSINESS OR INDUSTRY U.N.K.			11. BIRTHPLACE (County & State, or foreign country) LINCOLN Ne.B.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME C M CHRISTENSEN						14. MOTHER'S MAIDEN NAME UNK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. 1918-1919			17. INFORMANT 336-074992			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. Seizure and Resp. arrest DUE TO (b) Renal Failure and Pneumonia DUE TO (c) Metastatic Neck Carcinoma - 1° site CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN											
INTERVAL BETWEEN ONSET AND DEATH 2 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that it (this hospital) attended the deceased from Jan. 16 , 1967, to March 14 , 1967, that we last saw the deceased alive on March 13 , 1967, and that death occurred at 4:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Miguel R. Alonso						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED March 19, 1967		
22c. PHYSICIAN'S NAME (Type) Dr. Miguel R. Alonso						22d. ADDRESS Greater Balto. Medical Center					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/16/67			23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Hubbard Funeral Home						ADDRESS 4107 Wilkens Ave.			25a. REC'D BY REGISTRAR 31 MAR 16 1967		
						25b. REGISTRAR'S SIGNATURE J. Charles Judge					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03170

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03161

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b BALTIMORE		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. JOSEPH'S HOSPITAL		d. STREET ADDRESS 428 Folcroft 21224	
3 NAME OF DECEASED (Type or print) LEWIS		4 DATE OF DEATH Month 3 Day 20 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 17, 1942
9 AGE (In years last birthday) 24 yrs		10 IF UNDER 1 YEAR Months 3 Days 20 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Roads	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Lewis Cleaver Sr.		14 MOTHER'S MAIDEN NAME Ethel Wiegand	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 216-42-7884	
17 INFORMANT Lewis Cleaver Sr., Father, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive internal bleeding DUE TO (b) Laceration of spleen and lungs DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fatty alteration of liver			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver involved in three car accident	
20c. TIME OF INJURY Month, Day, Year Hour 4:50 pm 3-20 67	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Beltway	20f. (City or town) (County) (State) Baltimore Balto. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 3-21-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/24/67	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24 FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		25a. REC'D BY REGISTRAR MAR 23 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

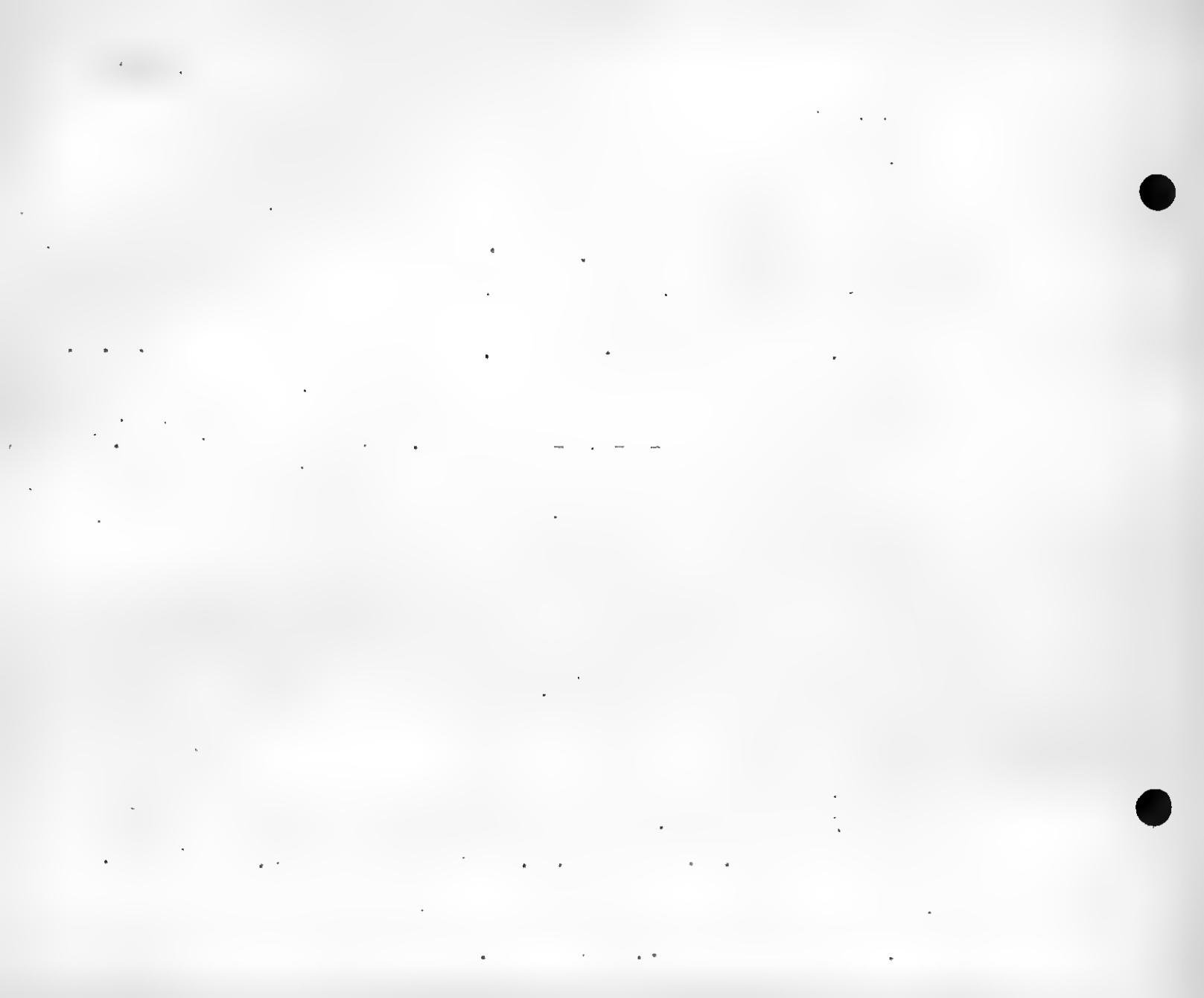


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03171					03162				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 33 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 56 Broadship Road					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 56 Broadship Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First John Middle J. Last Coburn					4. DATE OF DEATH Month March Day 16 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/2/84		9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Gen. Foreman			10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.			11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Coburn					14. MOTHER'S MAIDEN NAME Ellen Finnerty				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-07-6938-A		17. INFORMANT (Son) William L. Coburn			Address Maryland, 21222	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac accident - DUE TO Senility. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) As-c-v Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/16/67 to 3/16/67 , that (I) (we) last saw the deceased alive on 3/16/67 , 19 19 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.									
22a. SIGNATURE M. B. Davis					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/17/67		
22c. PHYSICIAN'S NAME (Type) Melvin B. Davis					22d. ADDRESS M. D. 6800 Mornington Rd. Dundalk, Md. 21222				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/20/67		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR John J. Duda					ADDRESS 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR MAR 20 1967 DATE		
					25b. REGISTRAR'S SIGNATURE Charles Judge				



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03172

CERTIFICATE OF DEATH

03163

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN It 8 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER, MD. d. STREET ADDRESS 125 CITY VIEW AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CLARA GENEVIEVE COLEMAN First Middle Last		4 DATE OF DEATH Month 3 Day 9 Year 1967	
5. SEX FEMALE	6 COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/08 9. AGE (In years last birthday) 58 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSISTANT HOSPITAL LAUNDRY		10b. KIND OF BUSINESS OR INDUSTRY WESTMINSTER, MD.	
11 BIRTHPLACE (County & State, or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME CLARENCE STAUP		14 MOTHER'S MAIDEN NAME GERTRUDE ETZLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-7317	
17. INFORMANT PATIENT CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 days YES	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-2 , 19 67 , to 3-9 , 19 67 , that (I) (we) last saw the deceased alive on 3-9 , 19 67 , and that death occurred at 10:45 AM , from causes and on the date stated above			
22a. SIGNATURE Mario B. Ines M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MARIO B. INES M.D.		22d. ADDRESS GBMCC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/13/67	23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDENS	23d. LOCATION (City or town) (County) (State) FINKSBURG MARYLAND
24. FUNERAL DIRECTOR J. E. Myers Jr. Westminster - MD.		25a. REC'D BY REGISTRAR MAR 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
25M 1/67

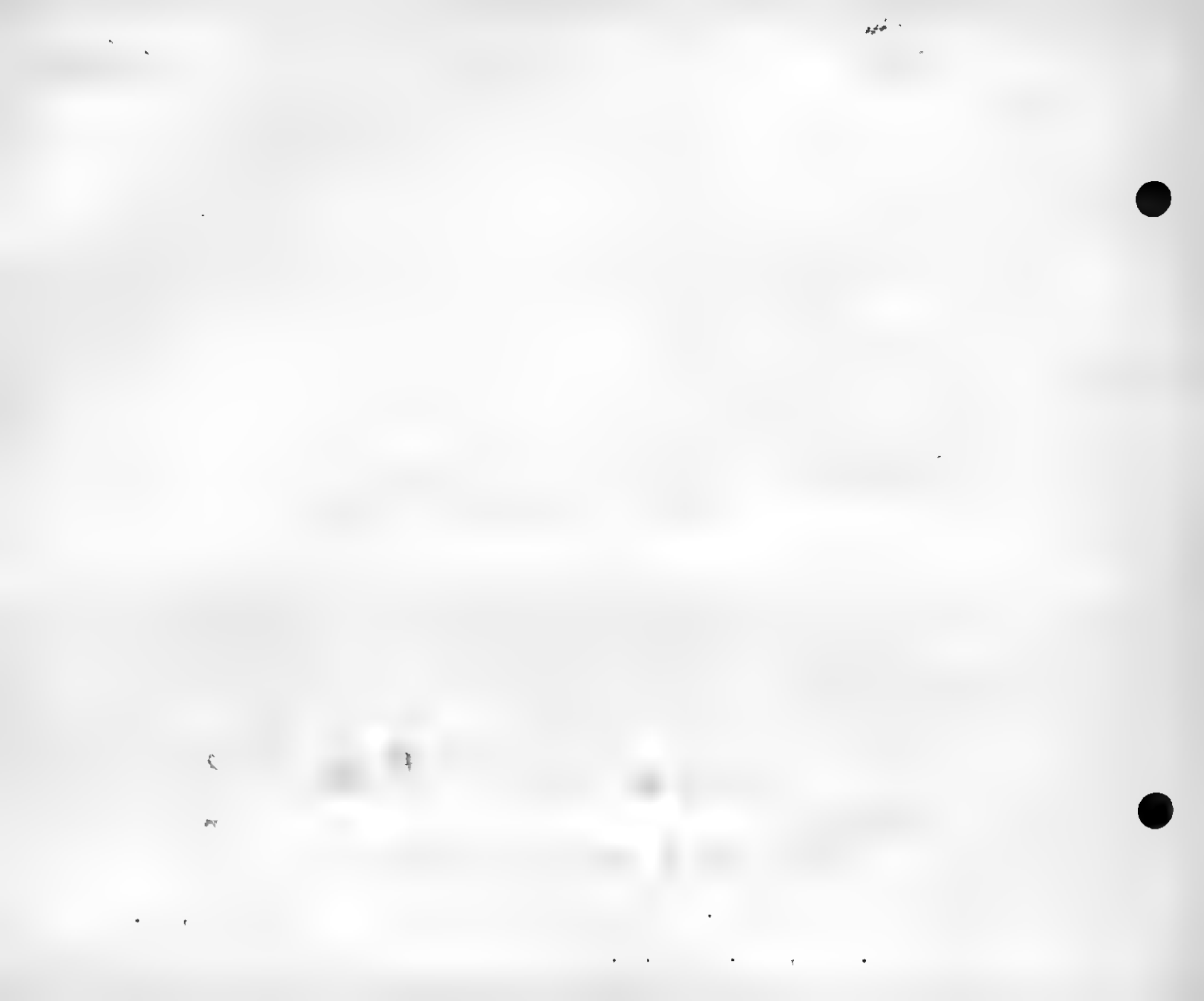
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03173

CERTIFICATE OF DEATH

03164

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21204</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>			d. STREET ADDRESS <u>1400 Jeffers Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Henry John Correlli</u>			4 DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>1967</u>		
5 SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-17</u>		9. AGE (In years last birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roofing (own)</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Chester, Penn.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13 FATHER'S NAME <u>Enrico Correlli</u>			14 MOTHER'S MAIDEN NAME <u>Rachella</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>XXXX No</u>		16 SOCIAL SECURITY NO <u>UNKN</u>		17 INFORMANT <u>Patient's Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1967</u> to <u>March 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 20, 1967</u> , and that death occurred at <u>4:20 P.M.</u> from causes on and on the date stated above					
22a SIGNATURE <u>J. Mellyza</u>			22b. DATE SIGNED <u>3/20/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>KEITH A. MANLEY GMC</u>			22d ADDRESS <u>Charles, Md</u>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>3/23/67.</u>		23c NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cemetery</u>	
23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>					
24 FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>			25a REC'D BY REGISTRAR DATE <u>MAR 22 1967</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03174

CERTIFICATE OF DEATH

03165

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 54 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 33 LOCUST DRIVE	
3. NAME OF DECEASED (Type or print) First JAMES Middle LEO Last COYLE		4. DATE OF DEATH Month MARCH Day 6 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 7, 1903	9. AGE (In years last birthday) yrs. 64	10. IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY STATE OF MD.		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN COYLE			
14. MOTHER'S MAIDEN NAME MARY MULLEN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			
16. SOCIAL SECURITY NO. 212 03 93 85		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. BRONCHOPNEUMONIA (b) ARTERIOSCLEROTIC HEART DISEASE WITH MURAL THROMBOSIS (c) PULMONARY AND SILENT INFARCTS					INTERVAL BETWEEN DEATH AND DEATH RECENT RECENT UNKNOWN RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN. 11 , 19 67 , to MARCH 6 , 19 67 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MARCH 6 , 19 67 , and that death occurred at 115A M, from causes and on the date stated above.					
22a. SIGNATURE <i>Peter V. Juvan</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-9-67	23c. NAME OF CEMETERY OR CREMATORY NEW CATHARAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR FARLEY CAVANAUGH		ADDRESS 6601 FRED AVE 21228 BALTIMORE		25a. REC'D BY REGISTRAR MAR 9 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #3387 11/3/67 DC

03175

CERTIFICATE OF DEATH

03166

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4207 1/2 Raspe Ave</u>		d. STREET ADDRESS <u>4207 1/2 Raspe Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARY</u> First Middle Last		4 DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>CAU</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-10-92</u>
9 AGE (In years last birthday) <u>74</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Poland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16 SOCIAL SECURITY NO <u>215-03-739A</u>		17. INFORMANT <u>Patient's Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Congestive Heart Failure</u> (b) <u>Right Upper Lobe Pneumonia</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>—</u> m <u>—</u> pm <u>19</u>	20d INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1967</u> to <u>March 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 15, 1967</u> , and that death occurred at <u>6:35 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Mr. A. Gongon</u>		22b. DATE SIGNED <u>March 15, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GONGON</u>		22d. ADDRESS <u>600 MC-Charles St - 112</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto, Md.</u>
24. FUNERAL DIRECTOR <u>John C Miller Inc. - 6415 Belair Rd.</u>		25a REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT

03176

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03167

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA-St. Joseph's Hospital		d. STREET ADDRESS 8742 Lackawanna Ave.	
3. NAME OF DECEASED (Type or print) Mary R. Davenport		4. DATE OF DEATH Month March Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1919
9. AGE (In years and birth day) 47 yrs		10. IF UNDER 1 YEAR Months 4 Days 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence J. Franz		14. MOTHER'S MAIDEN NAME Margaret Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-01-2902	
17. INFORMANT Mr. William H. Davenport		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5+ yrs (b) Sudden (c) 5+ yrs			INTERVAL BETWEEN ONSET AND DEATH 5+ yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED 3/9/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	
25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of body event within 72 hours after death.



03177

CERTIFICATE OF DEATH

03168

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2917 Dummurry Road		d. STREET ADDRESS 2917 Dummurry Road	
3 NAME OF DECEASED (Type or print) CHARLES First W. Middle DAVIS Last		4. DATE OF DEATH Month March Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1906
9 AGE (in years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months 1 Days 2 Hours 15 Min 00	
11b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest R. Davis	
14. MOTHER'S MAIDEN NAME Mary D. Rust		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Barbara Davis, 2917 Dummurry Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Ca to Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1621 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) emphysema, obstructed; congested Heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 19 63 to 3/22, 19 67 , that (I) (we) last saw the deceased alive on 3/22, 19 67 and that death occurred at 3:24 A.M. from causes and on the date stated above			
22a. SIGNATURE Paul G. Koukoulas		22b. DATE SIGNED 3/23/67	
22c. PHYSICIAN'S NAME (Type) Paul G. Koukoulas M.D.		22d. ADDRESS 6511 O'Donnell St.,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	23d. LOCATION (City or Town) (County) (State) Parkville, Md.
24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		25a. REC'D BY REGISTRAR MAR 27 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03178

CERTIFICATE OF DEATH

03169

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN 1b 1 Mo.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Home		d. STREET ADDRESS 18 Nunnery Lane	
3. NAME OF DECEASED (Type or print) Amy France Day		4. DATE OF DEATH Month March Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1880
9. AGE (in years) 86		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John France		14. MOTHER'S MAIDEN NAME Augusta Ernst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-54-8221	
17. INFORMANT Robert G. Parrott		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the left Breast DUE TO with metastases to Bone Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1963	20f. (City or town) (County) (State) 3/29/67
21. I certify that (I) (this hospital) attended the deceased from 1963 to 3/29/67 , that (I) was last saw the deceased alive on 3/29/67 , and that death occurred 12:30 P.M. from causes on and on the date stated above			
22a. SIGNATURE Dr. W.E. McGrath		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) Dr. W.E. McGrath		22d. ADDRESS 1303 Frederick Ave. Catonsville	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-1-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212		25a. REC'D BY REG. STRAR APR 4 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03179

03170

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Md. b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown				c LENGTH OF STAY IN 1b Rural- Randallstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home				d STREET ADDRESS 8931 Liberty Rd.			
3 NAME OF DECEASED (Type or print) Stanley Chester Day				4 DATE OF DEATH Month Mar. Day 1 Year 1967			
5 SEX M	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1887		9 AGE (In years lost birthday) yts 79	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner Bus Service Trans.			10b KIND OF BUSINESS OR INDUSTRY Trans.		11 BIRTHPLACE (County & State, or foreign country) Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Day				14. MOTHER'S MAIDEN NAME Martha Miller			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-07-9804		17 INFORMANT Stanley C. Day Jr.-8931 Liberty Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 1538 IMMEDIATE CAUSE (a) Carcinoma Colon c DUE TO metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 , to 3/1/1967 , that (I) (we) las saw the deceased alive on 2/28 19 67 , and that death occurred at 3/1 M, from causes and on the date stated above							
22a SIGNATURE VXS				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) Dr. Morton Ellin				22d ADDRESS 8629 Liberty Rd. Randallstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/67		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d LOCATION (City or town) (County) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



03180

CERTIFICATE OF DEATH

03172

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1st St - 4 c. LENGTH OF STAY in 1b		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph Hospital		d. STREET ADDRESS 326 East Belvedere Ave.	
3 NAME OF DECEASED (Type or print) THOMAS WILLIAM DEVOY		4 DATE OF DEATH Month March Day 16th Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 11th 1908
9 AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 5 Days 16 Hours 16 Min 16	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Rite Way Driving	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John DeVoy		14. MOTHER'S MAIDEN NAME Mary (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 212-03-1211	
17. INFORMANT Mrs. Dorothy C. DeVoy (Widow)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 3, 1966 , to March 16, 1967 , that (I) (we) last saw the deceased alive on 3/16/67 19 67 and that death occurred at 10 P.M. from causes and on the date stated above.			
22a SIGNATURE Charles E. Carr		22b DATE SIGNED 3/19/67	
22c PHYSICIAN'S NAME (Type) Charles E. Carr M.D.		22d ADDRESS 3900 N. Charles Street	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3/20/67	23c NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d LOCATION (City or Town) (County) (State) Balto
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25a REC'D BY REGISTRAR 21212	
25b REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 27 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03181

03173

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE HIGHLANDS</u> c. LENGTH OF STAY IN 1b <u>6-4-67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4106-OLD ANNAPOLIS ROAD (21237)</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE HIGHLANDS-21237</u> d. STREET ADDRESS <u>4106-OLD ANNAPOLIS RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY E. DEW</u> First Middle Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>NOV. 7, 1872</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (in years last birthday) <u>94</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>MARCH 3, 1967</u> Month Day Year 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD. USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> 13. FATHER'S NAME <u>CHARLES T. TURNER</u>		14. MOTHER'S MAIDEN NAME <u>MARY R. ALLISON</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>MRS. EDNA E. FONT 2 (DHT.)</u> Address <u>1221-PO+ADP+ST. BALTO MD 21230</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHERO-SCLEROSIS</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEMILENT</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>3-3</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-3</u> , 1967, and that death occurred <u>11:40 PM</u> on the causes and on the date stated above.			
22a. SIGNATURE <u>J. Duer Moories</u> 22c. PHYSICIAN'S NAME (Type) <u>J. DUER MOORIES</u>		22b. DATE SIGNED <u>3-6-67</u> 22d. ADDRESS <u>3105 BELAIR RD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>MARCH 7, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem</u>		23d. LOCATION (City, town or county) <u>BALTIMORE, MD.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>CURTIS E. EVANS</u> ADDRESS <u>1400 S. BALTO</u>		25a. REC'D BY REGISTRAR <u>11:06</u> 25b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. In by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

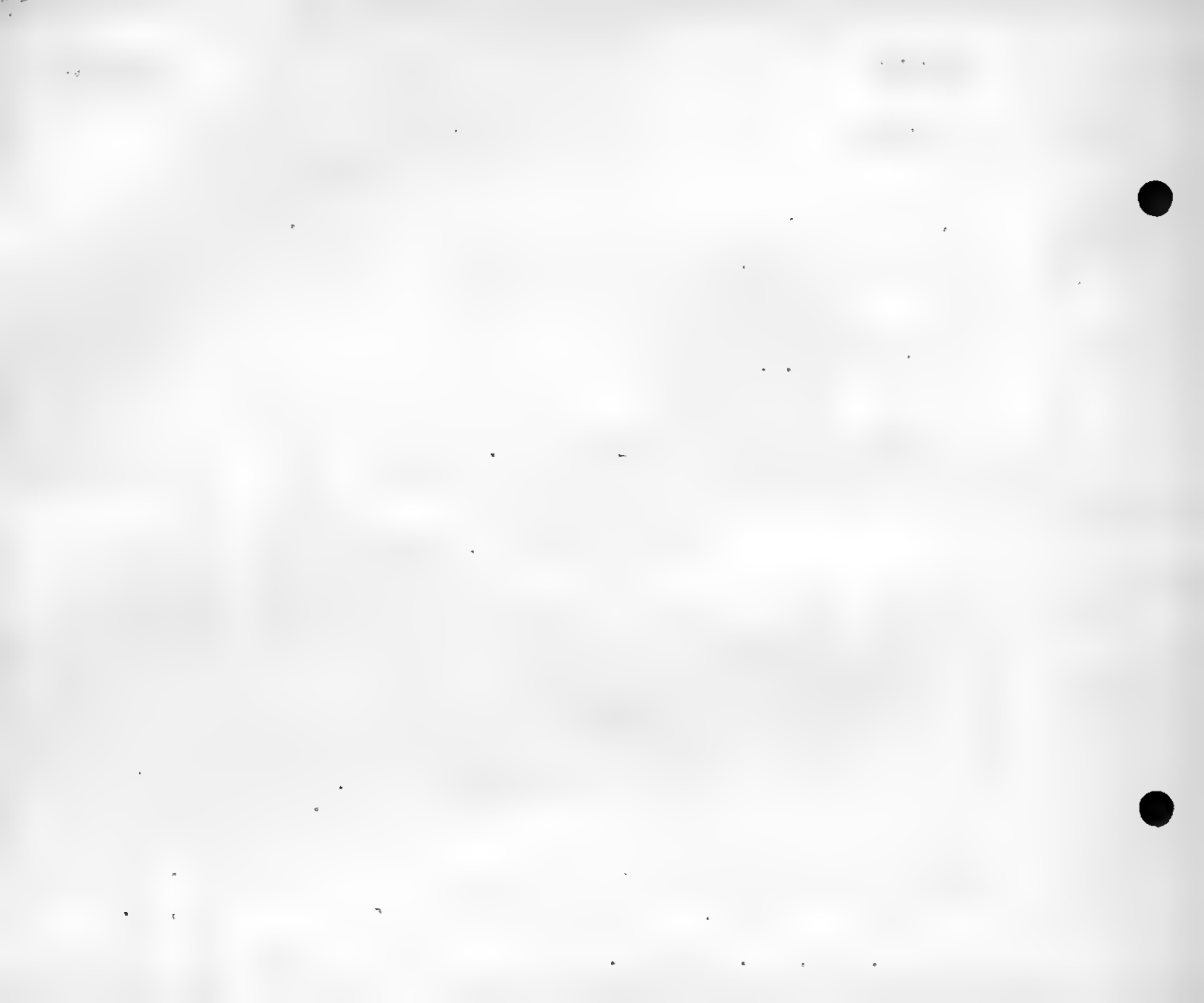
03182

CERTIFICATE OF DEATH

03174

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 8605 Dilegge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Dominic DiLegge, Sr. f. SEX Male g. COLOR OR RACE White h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> i. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Balto. City Employee j. 10b. KIND OF BUSINESS OR INDUSTRY k. BIRTHPLACE (County & State, or foreign country) Italy l. 12. CITIZEN OF WHAT COUNTRY? USA				4 DATE OF DEATH Month March Day 11 , Year 1967 5 AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR: Months Days Hours Min 13. FATHER'S NAME Anthony DiLegge 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO 219-32-1508 17. INFORMANT Mrs. Mary DiLegge Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that he (this hospital) attended the deceased from 3/5/ , 1967, to 3/11/ , 1967, that he (we) last saw the deceased alive on 3/11/ , 1967, and that death occurred at 11:25 AM, from causes and on the date stated above 22a. SIGNATURE <i>Jaime Singzon</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED March 11, 1967 22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D. 22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/15/67. 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS 25a. REC'D BY REGISTRAR MAR 13 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03183

CERTIFICATE OF DEATH

03175

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 15 <u>84 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hosp.</u>		d. STREET ADDRESS <u>23 North Ellwood Avenue</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Nellie Rebecca Dippel (Dippel)</u>		4 DATE OF DEATH Month Day Year <u>Mar. 11 19 67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-82</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. K. NO. OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland Baltimore U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ohliver Wentworth</u>		14. MOTHER'S MAIDEN NAME <u>Kate Hubbard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-54-3092</u>	
17. INFORMANT <u>Mrs Catherine Liebau</u>		Address <u>Spring Grove Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO (b) <u>Heart block</u> DUE TO (c) <u>Elephantiasis in both leg.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>12-6</u> , 19 <u>66</u> to <u>3-11</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-11</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>E. A. Felipe</u> M.D.		22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EVELIO A FELIPE</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air Maryland</u>
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03184

CERTIFICATE OF DEATH

03176

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 3241 MAGNOLIA AVENUE	
3 NAME OF DECEASED (Type or print) First Middle Last CARL HAROLD DIXON		4 DATE OF DEATH Month Day Year MARCH 26 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 6, 1897
9. AGE (in years last birthday) yrs 70		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
11. BIRTHPLACE (County & State or foreign country) WEST HILL, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM DIXON		14. MOTHER'S MAIDEN NAME MAMIE JENKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 333 14 96 38	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GARCINOMA OF TONGUE & FLOOR OF MOUTH Interval between onset and death UNKNOWN (b) BRONCHOPNEUMONIA, BILATERAL RECENT (c) PULMONARY EDEMA, MARKED, BILATERAL RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 6, 19 67 to MARCH 26, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 26, 19 67 , and that death occurred at 830P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY	23d. LOCATION (City or Town) (County) (State) DOGWOOD ROAD, BALTIMORE, MD.
24. FUNERAL DIRECTOR <i>Wm. J. Tickner & Sons</i>		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		26. NORTH & PENNSYLVANIA AVE. BALTIMORE, MD.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

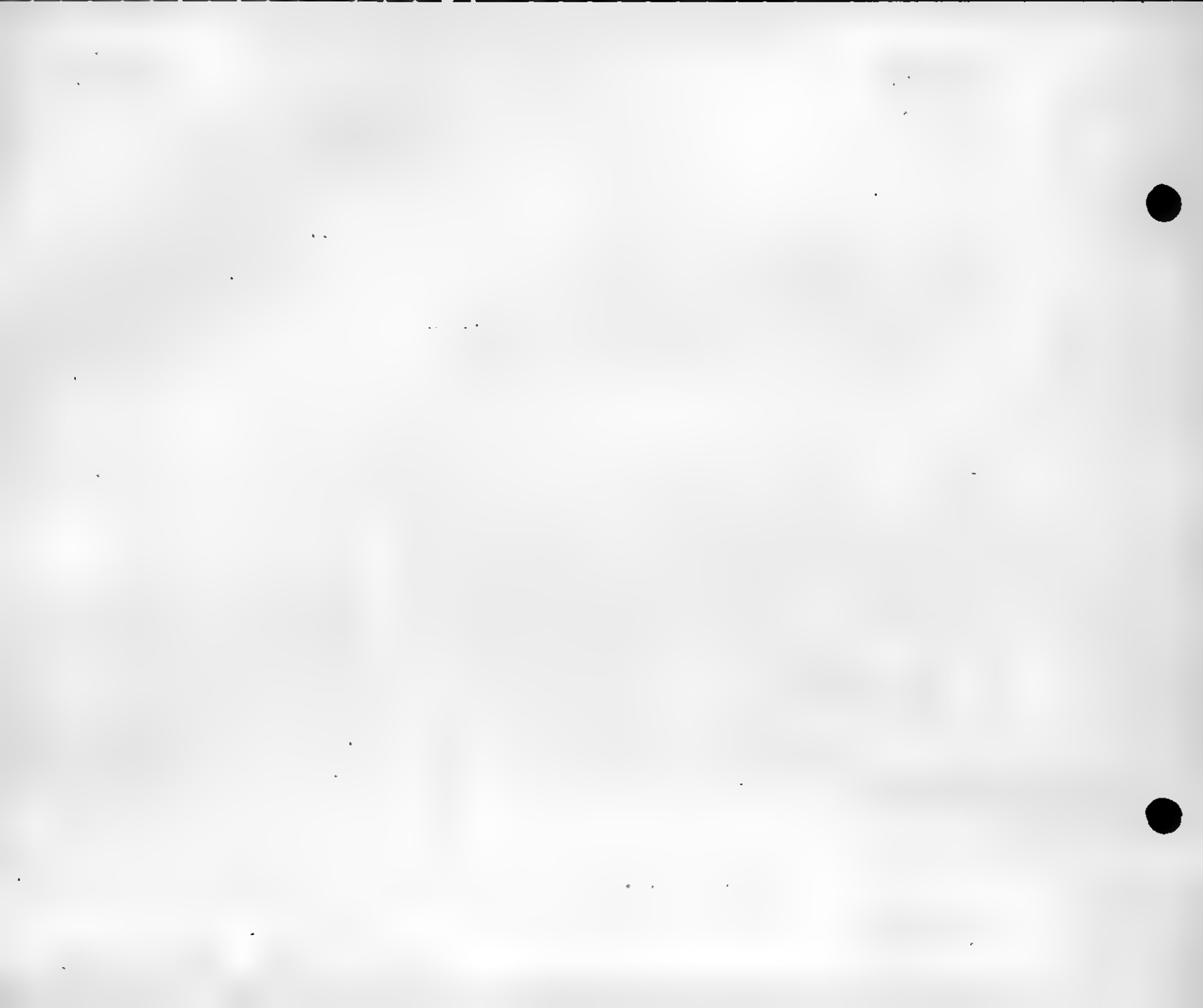
03185

CERTIFICATE OF DEATH

03177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN lb <u>7 yrs.</u>		d. STREET ADDRESS <u>2430 Etting St.</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Phillip Alexander Dixon</u>		4. DATE OF DEATH Month Day Year <u>March 21 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-16-44</u>
9. AGE (In years last birthday) <u>22 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Obadiah Thompson</u>		14. MOTHER'S M.A.DEN NAME <u>Ollie Lee Dixon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Medical Records, Rosewood State Hosp.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4331</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatiz heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>3-34</u> , 196 <u>6</u> , to <u>3-21</u> , 196 <u>7</u> , that (H) (we) last saw the deceased alive on <u>3/21 1967</u> , and that death occurred at <u>3:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Isolt Koppanyi, M.D.</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Isolt Koppanyi, M.D.</u>		22d. ADDRESS <u>Rosewood State Hosp., Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. Md.</u>	
24. FUNERAL DIRECTOR <u>Geo. J. Kilian 1347 Calhoun St.</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

03186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03178

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN It 03-1		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Essex	
3. NAME OF DECEASED (Type or print) RALPH First Middle Last DODD		4. DATE OF DEATH (Pronounced) March 30, 1967 Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/22 9. AGE (In years last birthday) 44 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airplane Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Wesley Dodd 14. MOTHER'S MAIDEN NAME Lily Justice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Alma L. Dodd 42 Chandell Rd. Essex, Md. Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon Monoxide DUE TO (c) Conflagration	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Mattress caught fire	
20c. TIME OF INJURY Month Day Year 3-29 or 3-30 1967 Hour a.m. pm	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Essex BALTIMORE MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED March 31, 1967 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 3/31/67	23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR James M. Fields - Balto., Md. ADDRESS		23d. LOCATION (City or town) (County) (State) Weaverville, North Carolina	
25a. REC'D BY REGISTRAR DATE APR 4 1967		25b. REGISTRAR'S SIGNATURE Charles Justice	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03187

CERTIFICATE OF DEATH

03179

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8051 Philadelphia Road		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale d. STREET ADDRESS 8051 Philadelphia Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ELIZABETH Middle DOERING Last 4 DATE OF DEATH March 3 19 67 Month Day Year		5 SEX female 6 COLOR OR RACE white 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH 8/11/93 9. AGE (in years last birthday) 73 yrs WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instrument Packer 10b. KIND OF BUSINESS OR INDUSTRY Bendix Corp. 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md. 12 CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Peter Hoffman 14. MOTHER'S MAIDEN NAME Minnie Borgmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 215-22-0563 16 SOCIAL SECURITY NO 17. INFORMANT Margaret Ciampa, dght, 8051 Phila. Rd. Address 21206			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 157X DUE TO Hepatic Failure - Coma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Carcinoma Pancreas. (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from October , 19 67 , to Mar 3 , 19 67 , that (I) (we) last saw the deceased alive on 3- 19 67 , and that death occurred at 8:22 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. John B. Littleton M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 1012 Old North Point Rd.		22b. DATE SIGNED 3-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/6/67 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane 25a. REC'D BY REGISTRAR MAR 6 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PARKTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Sparks.</u>	
c. LENGTH OF STAY in 1b <u>2 days</u>		d. STREET ADDRESS <u>Cold Bottom Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MASON</u>	First <u>Ted</u> Middle <u>Dolly</u> Last <u>Dolly</u>	4. DATE OF DEATH <u>March 13, 1967</u>	Month <u>March</u> Day <u>13</u> Year <u>1967</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 26, 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic - Gas Engines</u>		11. BIRTHPLACE (State or foreign country) <u>Key, W. Va.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Oscar S. Dolly</u>		14. MOTHER'S MAIDEN NAME <u>Lennie Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-7034</u>	
17. INFORMANT <u>Mrs. Josephine Meads</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A.M. France</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A.M. FRANCE</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>PARKTON</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>March 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dolly Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Old Fields, W. Va.</u>
24. FUNERAL DIRECTOR <u>J. Jacob Kortenstien, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03189					03181				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		BALTIMORE			a. STATE		MARYLAND		
		MARYLAND			b. COUNTY		BALTIMORE		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
BALTIMORE			LIFE		BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
GREATER BALTIMORE MEDICAL CENTER					517 PATUXENT AVE.				
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH
BABY BOY							DANNENFELSER		Month Year
									MARCH 20 1967
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/20/67		Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
CHILD					BALTIMORE, MARYLAND		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOSEPH DANNENFELSER					SHARON ANNE WHEELER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
					JOSEPH DANNENFELSER		517 PATUXENT AVE		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									NEONATAL ATELECTASIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									(b) IMMATURITY (700 GMS.)
									(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (this hospital) attended the deceased from 3/20, 1967, to 3/20, 1967, that (we) last saw the deceased alive on 3/20/67, and that death occurred at 1:00 PM, from the causes and on the date stated above.									
22a. SIGNATURE								22b. DATE SIGNED	
Margaret E. Lang MD								3/20/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
MARGARET E. LANG MD				GREATER BALTIMORE MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		MAR 22 1967		HOLYREDEEMER CEMETERY		4430 BELAIR ROAD MD			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
DIPPEL BROS INC 1800 E LOMBARD ST				MAR 23 1967		J Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03190		CERTIFICATE OF DEATH				03182			
1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b <u>3 y. 15. 8 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PERRY HALL 21128</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					d. STREET ADDRESS <u>9937 Richlyn DR.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>n.m.y.</u> Last <u>DRUMMOND</u>					4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1967</u>				
5 SEX <u>FEMALE</u>		6 COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>8/20/92</u>		9 AGE (In years last birthday) <u>74</u> yrs	
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11 BIRTHPLACE (County & State, or foreign country) <u>GEORGETOWN, MARYLAND</u>			12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JOSEPH A. VESELY</u>					14. MOTHER'S MAIDEN NAME <u>MARY Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>LOUIS F. VESELY</u> Address <u>Richlyn 9937 xxxxxx DR.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1</u> DUE TO <u>1</u> (c) <u>1</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>63</u> , to <u>3-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10 1967</u> , and that death occurred at <u>2 p.m.</u> from causes and on the date stated above.									
22a. SIGNATURE <u>Morris Meiller</u>						M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>MARCH 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS MEILLER</u>						22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/15/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03191

CERTIFICATE OF DEATH

03183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN		c. LENGTH OF STAY IN 1b 10 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTO. COUNTY GENERAL HOSPITAL		e. STREET ADDRESS 6992 Apt. 1C Millbrook	
3. NAME OF DECEASED (Type or print) First ISADORE Middle (NMI) Last DUBANSKY		4. DATE OF DEATH Month 3 Day 27 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocer	9. AGE (In years last birthday) 72 yrs.
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BEARNARD DUBANSKY		14. MOTHER'S MAIDEN NAME LENA BECKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 800-00-5648	
17. INFORMANT Mrs. Ray Dubansky, 6992 Millbrook		Address Park Dr. Apt. - 1-C	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____			INTERVAL BETWEEN ONSET AND DEATH 5 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/22/67 , 19____, to 3/27/67 , 19____, that (I) (we) last saw the deceased alive on 3/27/67 , 19____, and that death occurred at 9:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Dr. Samuel Tompakou		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL TOMPAKOU		22d. ADDRESS Baltimore County General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Ohr Knesseth Israel	23d. LOCATION (City or town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reisterstown		25a. REC'D BY REGISTRAR 31 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03192

CERTIFICATE OF DEATH

03184

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) (Rural) Baltimore		c. LENGTH OF STAY IN ib c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9112 Orbitan Road		d. STREET ADDRESS 9112 Orbitan Road	
3 NAME OF DECEASED (Type or print) ROSE FRANCES DUNKEL		4. DATE OF DEATH Month March Day 13, Year 19 67.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1896.
9. AGE (in years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 70 Days 13, Hours 19 Min. 67.	11. BIRTHPLACE (County & State or foreign country) Maryland
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13. FATHER'S NAME Samuel French		14. MOTHER'S MAIDEN NAME Anna E. Gilbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-12-9187	
17. INFORMANT Mrs. Frances Petza		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DUE TO RENAL DISEASE (c)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 1939 to 3-10, 1967, that (I) (we) last saw the deceased alive on 3/10, 1967, and that death occurred at 5P M, from causes and on the date stated above.			
22a. SIGNATURE Anthony J. Thomas MD		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type) ANTHONY J THOMAS MD		22d. ADDRESS 4600 YORK ROAD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/67.	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution before admission) a. STATE Md 21222 b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. LENGTH OF STAY IN 1b' 11 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2021 DUNDALK AVE						d. STREET ADDRESS 2021 DUNDALK AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY KELLEY DURACZYK						4. DATE OF DEATH Month Day Year 3 / 25 / 1967					
5. SEX FEMALE CAUCASIAN		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/13/1917		9. AGE (In years last birthday) yrs. 49		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY RETL. GROCERY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME ANDREW KELLEY						14. MOTHER'S M maiden name ELMER J. DURACZYK - #2					
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO 234/10/0846		17. UNEMPLOYED FRADA SPARKS					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 1975 IMMEDIATE CAUSE (a) Anemia DUE TO Generalized Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO G.I. bleeding (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN 2, 1967 , to MARCH 25, 1967 , that I last saw the deceased alive on MARCH 25, 1967 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) BALTIMORE, Md DATE SIGNED 3/25/67 ACTUAL SIGNATURE George J. Dendrin M.D. Z. F. Read PHYSICIAN'S NAME (Type) GEORGE J. DENDRIN											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/29/67		22c. NAME OF CEMETERY OR CREMATORY GRONS. FAITH			22d. LOCATION (City, town, or county) (State) BALTO. Co., Md		
23. FUNERAL DIRECTOR'S SIGNATURE W. Bruce Shadykewich, Inc. ADDRESS						24a. REC'D BY REGISTRAR MAR 28 1967		24b. REGISTRAR'S SIGNATURE Charles Judge			

VS AIS (4)
15M 9/SS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #23b Film #18-6 3/8/67 ps

03194

CERTIFICATE OF DEATH

03186

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>509 Old Home Road</u>		d. STREET ADDRESS <u>509 Old Home Road</u>	
3. NAME OF DECEASED (Type or print) - First <u>John</u> Middle <u>B.</u> Last <u>Duvall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1881</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Pipe Coverer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Duvall</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216099043</u>	
17. INFORMANT <u>Joseph Duvall</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerosis of the Heart Disease</u> DUE TO (b) <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>3-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-10</u> 19 <u>67</u> , and that death occurred at <u>11 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>3209 North Point Road</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wyman K. Wong</u>		22d. ADDRESS <u>Baltimore, Md. 21222</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

WYMAN K. WONG, M.D.

M.D. ATTENDING PHYS.

MED. DIRECTOR

STAFF Charles Mont Medical Center



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03195

CERTIFICATE OF DEATH

03187

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN lb <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>George XXXXXXXX Eberle</u>		4 DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1883</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b KIND OF BUSINESS OR INDUSTRY <u>RETAIL Florist</u>	9 AGE (In years last birthday) <u>83</u> yrs. If UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u> If UNDER 24 HRS: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland BALTO.</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXX JOHN EBERLE</u>		14. MOTHER'S MAIDEN NAME <u>LENA SCHWARTZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO <u>215-32-7887-A</u>	
17. INFORMANT <u>Mr. RAY EBERLE (son)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Middle Cerebral</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1967</u> , to <u>March 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u>5:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Suzelina M. Oteyza</u>		22b. DATE SIGNED <u>March 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUDILINA M. OTEYZA</u>		22d. ADDRESS <u>GBMC-6701 N. CHARLES, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FIRST EVANGELICAL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>
24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS INC. BALTIMORE MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03196

CERTIFICATE OF DEATH

03188

1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>8 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 TERRACE ROAD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>				d. STREET ADDRESS <u>2 TERRACE ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>BURNICE SUSAN ECCARD</u>				4 DATE OF DEATH Month Day Year <u>3 / 14 / 1967</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/17/88</u>	9 AGE (In years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DAVID RIDENOR</u>				14. MOTHER'S MAIDEN NAME <u>LIDDIE REESE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NA</u>		16 SOCIAL SECURITY NO <u>220-28-928</u>		17. INFORMANT <u>PATIENT CHART</u> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE & ARTERIOSCLEROTIC</u> DUE TO (b) <u>CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIAL ASTHMA</u>							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>67</u> to <u>3/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/14</u> , 19 <u>67</u> , and that death occurred on <u>7:31 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John E. Adams</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. ADAMS</u>				22d. ADDRESS <u>GREATER BALTO. MED. CENTER</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bever Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Beaver Creek, Md.</u>	
24. FUNERAL DIRECTOR <u>John H. Bast, Jr.</u>				25a. REC'D BY REGISTRAR <u>21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03197

CERTIFICATE OF DEATH

03189

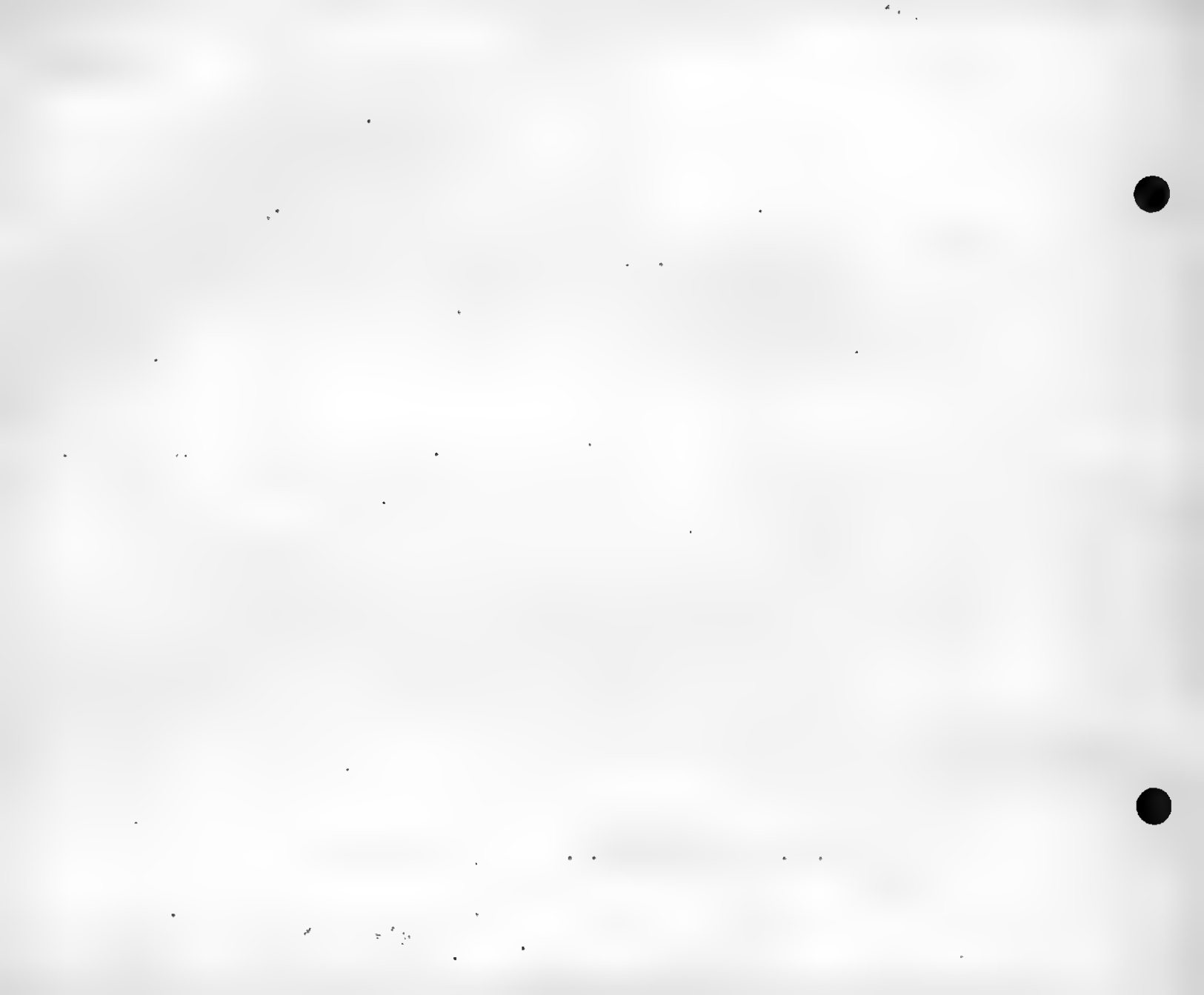
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>St. Clement's Infirmary</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Einhaus</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1897</u>
9. AGE (in years last birthday) yrs <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roman Cath. Priest</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.S.S.R.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Einhaus</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hilen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>Unk.</u>	
17. INFORMANT <u>Rev. Henry V. Sattler, 1225 E. Eager St.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>66</u> , to <u>3/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/12</u> 19 <u>66</u> , and that death occurred at <u>9:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Henry J. Houska</u>		22b. DATE SIGNED <u>3/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY J. HOUSKA M.D.</u>		22d. ADDRESS <u>333 S. EAST AVE BALTO MD 21224</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03198					03190				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>_____</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>1-Day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Home</u>					d. STREET ADDRESS <u>4709 Sayer Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elsie J. H. Elenbrok</u>			First Middle Last		4. DATE OF DEATH <u>March 24, 19 67</u>		Month Day Year		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19, 1885</u>		9. AGE (in years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>_____</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>? Krumpholz</u>					14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>21-43-4471</u>		17. INFORMANT <u>Amelia J. Wehrle 4709 Sayer Ave. Balto. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4321 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C. V. disease</u> (c) <u>_____</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>?</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stroke</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>_____</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 13, 1967</u> to <u>March 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 23, 1967</u> , and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>D. C. MacLaughlin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>				22d. ADDRESS <u>303 N. Rolling Road</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loulon Park Cem.</u>		23d. LOCATION (city, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave, Balto. Md.</u>						25a. REC'D BY REGISTRAR <u>DA MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

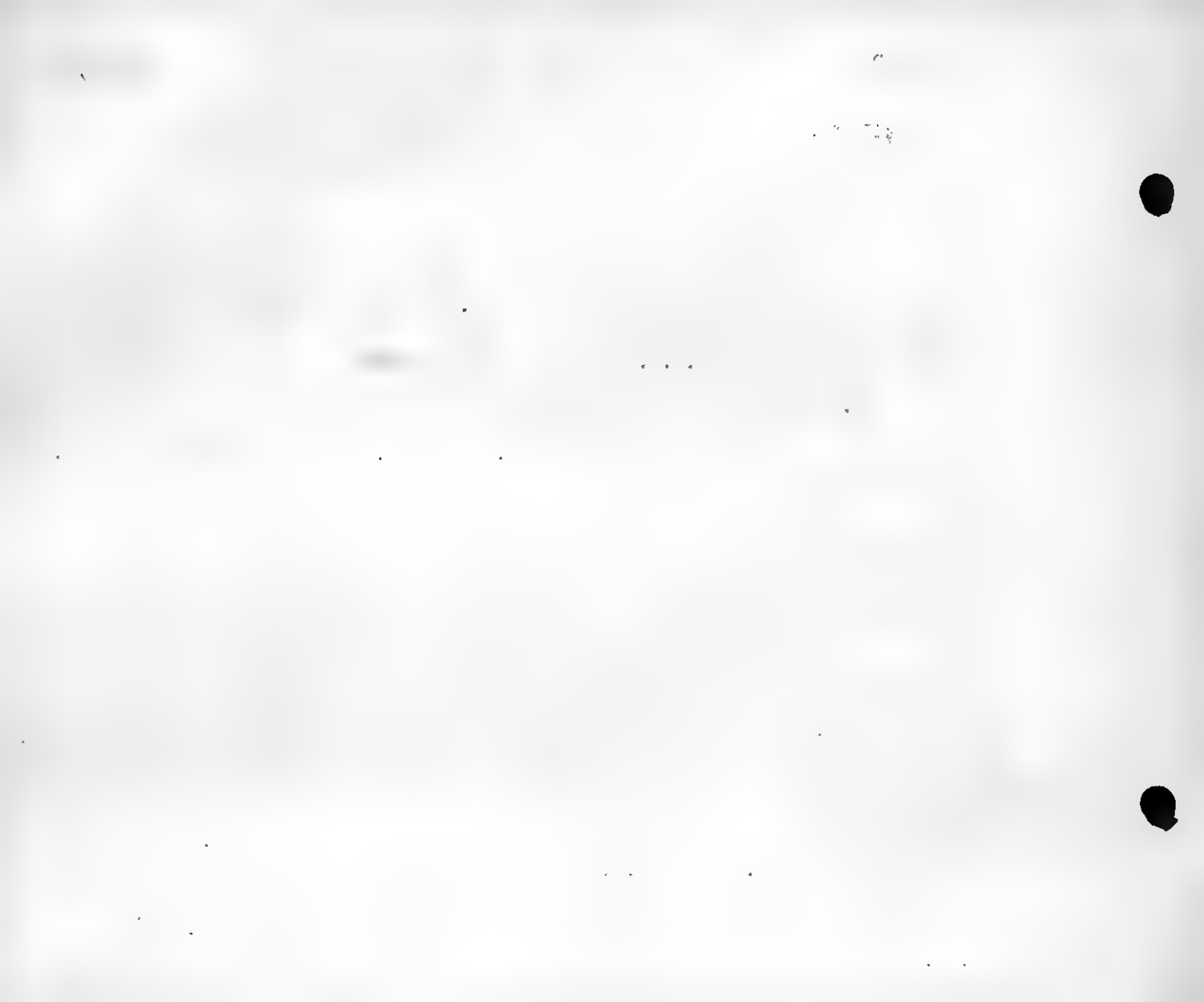
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03193

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03191

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b Reisterstown		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eline Funeral Home		d. STREET ADDRESS Dover Road	
3 NAME OF DECEASED (Type or print) DOROTHY ANN ELLIOTT		4 DATE OF DEATH Month 3 Day 6 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 5, 1912
9 AGE ("n years lost birthday") 55 yrs.		10 IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Secretary at C.R.I.		10b. KIND OF BUSINESS OR INDUSTRY Indiana	
11 BIRTHPLACE (State or foreign country) Indiana		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Walter E. Kirby		14. MOTHER'S MAIDEN NAME Lula Crooks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Mr. Morris A. Elliott	
17 INFORMANT Mr. Morris A. Elliott		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple injuries DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was involved in collision of 2 cars and gas truck	
20c. TIME OF INJURY Month Day Year 12:45 pm 3 -6 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Street	20f. (City or town) (County) (State) Westminister Carroll Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz		22. DATE SIGNED 3-6-67	
EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		Address (Street, city, town, or county) Greenmount Cemetery Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/7/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24 FUNERAL DIRECTOR J. F. Eline & Sons		25a. REC'D BY REGISTRAR 1967	
ADDRESS Reisterstown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03200

CERTIFICATE OF DEATH

03192

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 21214	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holly Hill Manor</u>		d. STREET ADDRESS <u>6405 Hartford Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>M.</u> Last <u>Endres</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 17, 1901</u>
9 AGE (in years lost birthday) <u>65</u> yes		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Irvin Alsrue</u>		14. MOTHER'S MAIDEN NAME <u>Olga ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-52-6716</u>	
17. INFORMANT <u>Endres</u> Address <u>same</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arteriosclerotic C-V disease</u> (c) <u>Terminal uremia</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis 1952</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 24, 1956</u> to <u>March 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1967</u> , and that death occurred at <u>4:10 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>H.V. Harbold</u> M.D.		22b. DATE SIGNED <u>March 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.V. HARBOLD M.D.</u>		22d. ADDRESS <u>4706 Harbold Rd Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	
25a. REC'D BY REGISTRAR <u>DATE MAR 20 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03201					CERTIFICATE OF DEATH					03193				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. LENGTH OF STAY IN 1b <u>1 yr 2 mon +</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21212 Rogers Forge</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulaney Towson Nursing Home</u>					d. STREET ADDRESS <u>255 Rogers Forge Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>F.</u> Last <u>Englar</u>					4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 67</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21, 1885</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u> </u>					11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County, Maryland</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>Charles Franklin</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Shipley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u> </u>					17. INFORMANT Address <u>Baltimore 04</u> <u>Dulaney Towson Nursing Home, 111 West Road</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myelogenous</u> <u>5271</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				
20f. (City or town) (County) (State) <u> </u>					21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1964</u> to <u>Mar 14 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 14 1967</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED <u>3/15/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>M Paul Byerly</u>					22d. ADDRESS <u>5820 York Rd Balto 12 Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>3/16/1967</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>				
23d. LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>					24. FUNERAL DIRECTOR <u>Wm. J. Tinkner & Sons</u>					25a. REC'D BY REGISTRAR DATE <u>MAR 17 1967</u>				
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>														

1. 10. 10



03202

CERTIFICATE OF DEATH

03194

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>		d. STREET ADDRESS <u>825 E. Lake Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>CLARA ELLA ENSOR</u>		4. DATE OF DEATH Month Day Year <u>March 4 1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1889</u>
9 AGE (In years lost birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min <u>4 19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William W. Smoot</u>		14. MOTHER'S MAIDEN NAME <u>Clara R. Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Mr. Ira Ensor</u>		Address <u>same address as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis, abdomen</u> DUE TO (b) <u>Acute renal insufficiency</u> DUE TO (c) <u>Arteriosclerosis cardiovascular diseases</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>3-4</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-4</u> 19 <u>67</u> , and that death occurred at <u>12:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Marchena</u>		22b. DATE SIGNED <u>3-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>OCTAVIO DE MARCHENA</u>		22d. ADDRESS <u>MD.</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		23e. REGISTERAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Wm. F. Tidman & Son</u>		24b. ADDRESS <u>Baltimore, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03203

03195

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Inverness		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1731 Inverness Ave.		d. STREET ADDRESS 1766 Brookview Rd # 22	
3. NAME OF DECEASED (Type or print) First Middle Last MARY JANE ERHARDT		4. DATE OF DEATH Month Day Year March 31, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1915
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer McDonald		14. MOTHER'S MAIDEN NAME Mary Donoghue	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-9218	
17. INFORMANT George W. Erhardt		Address Same.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of the Liver (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED When a Not While at work at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 30, 1967 to Nov 31, 1967 , that (I) (we) last saw the deceased alive on Nov 30, 1967 , and that death occurred at 4:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stephen C. Mackowiak M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S E (Type) Stephen C. Mackowiak		22d. ADDRESS 6714 Holabird Ave., Balto., 24, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-3-67.	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City, town or county) (State) 7401 German Hill Rd., Ba. Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. Zeller		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03204

Item #15 Film #3 3/11/67 pc

CERTIFICATE OF DEATH

03196

1. PLACE OF DEATH a. COUNTY Baltimore County Catonsville MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raffaele or Ralph Esposito		4. DATE OF DEATH March 8 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1st-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Retired		10b. KIND OF BUSINESS OR INDUSTRY Tailor Shop	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dominic Esposito		14. MOTHER'S MAIDEN NAME Balbina Adriano	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 115-03-5277A	
17. INFORMANT Josephine Esposito (Wife)		Address 5625 Lothian Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Chronic brain syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Multiple strokes (c) Parkinsonism 2 yrs. 2 yrs.			INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 2 yrs. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Parkinsonism 2 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/3/67 , 19 67 , to 3/8/67 , that (I) (we) lost saw the deceased alive on 3/8/67 and that death occurred grossly from causes and on the date stated above.			
22a. SIGNATURE W E McGrath		22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) W E McGrath		22d. ADDRESS 1303 Frederick Rd. Catons. 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13-67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City or Town) (County) (State) 4430 Belair Rd. Balt. Md.
24. FUNERAL DIRECTOR Frank DellaNoce		25a. REC'D BY REGISTRAR 322 S. High St.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 10 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03205

CERTIFICATE OF DEATH

03197

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 6500 RIVERVIEW AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWIN Middle WILMER Last EWING JR.				4. DATE OF DEATH Month MARCH Day 2 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 13, 1898	
9. AGE (in years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN W. EWING				14. MOTHER'S MAIDEN NAME SARAH E. JACKSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO 213 18 77 19		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, RECENT DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE (c) PULMONARY EMPHYSEMA BRONCHIAL ASTHMA						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 2 , 19 67 to MARCH 2 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 2 , 19 67 , and that death occurred at 1225A , from causes and on the date stated above.							
22a. SIGNATURE <i>Di Lok Premasathian</i> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) DILOK PREMASATHIAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/6/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE PARK NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ULRICH FUNERAL HOME				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

DUNDALK AVE. BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03206

CERTIFICATE OF DEATH

03198

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Baltimore</u> (342)		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7829 Wendover Ave</u>		d. STREET ADDRESS <u>7829 Wendover Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Ellen V. Turner</u> First Middle Last		4 DATE OF DEATH <u>3-20-67</u> Month Day Year	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1888</u> 78 yrs
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Constance</u>		14. MOTHER'S MAIDEN NAME <u>Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>John Turner</u> Address <u>7829 Wendover Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular</u> DUE TO <u>renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19, to <u>3-21-67</u> , 19, that (I) (we) last saw the deceased alive on <u>3-14-1967</u> , and that death occurred at <u>11:30 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>G. W. Peake</u>		22b. DATE SIGNED <u>3-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. W. PEAKE</u>		22d. ADDRESS <u>4508 Hanford Road Balto 21214</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Lee S. Lee</u> Address <u>7400 Hanford Road</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 22 1967</u>			

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03207

CERTIFICATE OF DEATH

03199

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardholders. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN b. <u>4 years</u>		d. STREET ADDRESS <u>Washington County Welfare Board</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FEESER, Baby Boy (Billy Friend)</u>		4. DATE OF DEATH <u>3 28 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/62</u>
9. AGE (In years last birthday) <u>4 yrs.</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Betty Feeser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia bilateral</u> 471X DUE TO (b) <u>Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Institutionalization, Kernicterus, Encephalomyelopathy</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that He (this hospital) attended the deceased from <u>3-20</u> <u>1963</u> to <u>3-28</u> <u>1967</u> , that he (we) last saw the deceased alive on <u>3-28</u> <u>1967</u> , and that death occurred at <u>6:30</u> <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Jones</u>		22b. DATE SIGNED <u>29 Mar 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A Jones</u>		22d. ADDRESS <u>Rosewood State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosewood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Owings Mills, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

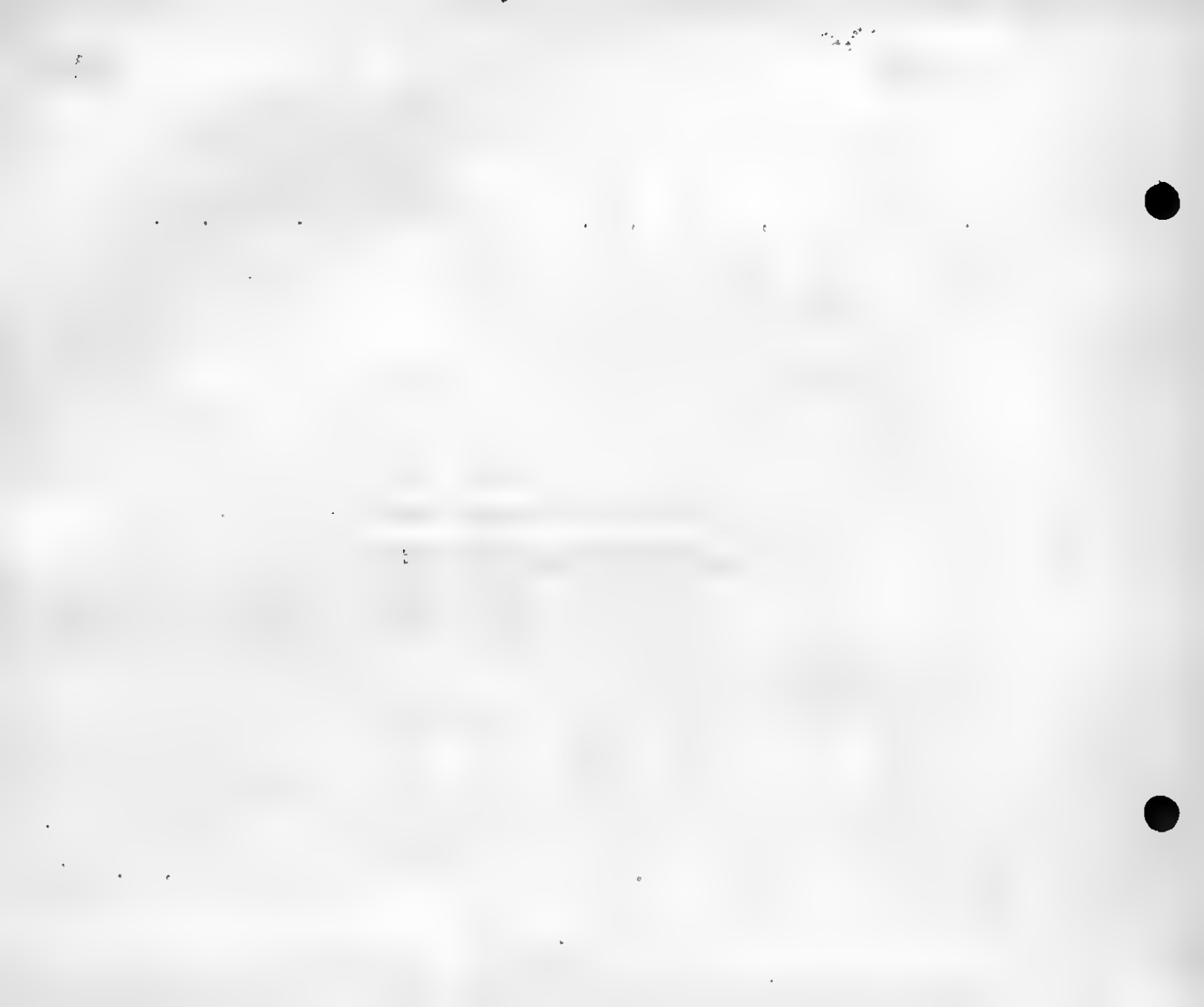
03208

CERTIFICATE OF DEATH

03200

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 46 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Baltimore, Md. 21204				d. STREET ADDRESS 7733 Bay Lays Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY FISCHER				4. DATE OF DEATH Month 2123 Day Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-02		9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY TAVERN		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CIT ZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John Fischer				14. MOTHER'S MAIDEN NAME Lillian NARR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 216-01-6364		17. INFORMANT Charlotte Fischer 7733 Bay Lays Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage, right occipital parietal lobe. DUE TO (b) Hypertensive cardiovascular disease. DUE TO (c) Tumor of right adrenal gland.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 20 (this hospital) attended the deceased from 3-22 , 19 67 to 3-27 , 19 67 , that 20 (we) last saw the deceased alive on 3-27 , 19 67 , and that death occurred at 11:08 AM , from causes and on the date stated above.							
22a. SIGNATURE M.S. Cockburn M.D.				22b. DATE SIGNED March 27, 1967		22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.	
22d. ADDRESS 7620 York Road, Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/31/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR CHAR. T. EVANS & Son 8802 Hartford Rd				25a. REC'D BY REGISTRAR MAR 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
03203		CERTIFICATE OF DEATH		03201	
1 PLACE OF DEATH a COUNTY BALTIMORE b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND c LENGTH OF STAY IN b 27 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d STREET ADDRESS 1728 N. BENTALOU STREET e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last FLOYD R. FORD		4 DATE OF DEATH Month Day Year MARCH 2 19 67			
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JULY 14, 1919	9 AGE (In years last birthday) yrs. 47	IF UNDER 1 YEAR Months Days Hours Min 2 19 67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b KIND OF BUSINESS OR INDUSTRY CLOTHING COMPANY		11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME FLOYD FORD		14 MOTHER'S MAIDEN NAME MYRTLE GROSS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16 SOCIAL SECURITY NO 216 07 47 42		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 5872 IMMEDIATE CAUSE (a) PERITONITIS DUE TO (b) PANCREATIC CYST WITH RUPTURE INTO ABDOMINAL CAVITY DUE TO (c) PULMONARY CONGESTION AND EDEMA		19 INTERVAL BETWEEN ONSET AND DEATH RECENT			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PULMONARY CONGESTION AND EDEMA		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/3/67 , 19__, to 3/2/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/2/67 , 19__, and that death occurred at 6:45AM , from causes and on the date stated above.					
22a SIGNATURE J. D. Talbert		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED 3/2/67	
22c PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3-6-67		23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
23d LOCATION (City or Town) (County) (State) BALTIMORE, MD.					
24. FUNERAL DIRECTOR Vernon R. Bailey		ADDRESS 1348 N. CALHOUN ST. BALTIMORE, MD.		25a REC'D BY REGISTRAR DATE MAR 6 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03210

CERTIFICATE OF DEATH

03202

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 LORRAINE		d. STREET ADDRESS 403 LORRAINE	
3. NAME OF DECEASED (Type or print) LLOYD B. FOSTER		4. DATE OF DEATH Month MAR. Day 8 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 27 1895
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CO.	
11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN FOSTER		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. ?	
17. INFORMANT MARIE FOSTER		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) post-sclerotic heart disease DUE TO (c) last.			INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Scabies			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July, 1965 to 3-7-1967 , that (I) (we) last saw the deceased alive on 2-27 1967 , and that death occurred at 1:40 AM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) W. K. WONG M.D.		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22e. NAME OF HOSPITAL OR INSTITUTION Charlesmont Medical Center			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/10/67	
23c. NAME OF CEMETERY OR CREMATORY LUTHERAN IMMEDIATELY		23d. LOCATION (City or Town) (County) (State) BALTO. MD	
24. FUNERAL DIRECTOR J.G. CONNELLY SONS		25a. REC'D BY REGISTRAR MAR 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03211

03203

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 1281 Cedarcroft Rd.	
3. NAME OF DECEASED (Type or print) Charles Francis		4. DATE OF DEATH Month 3 Day 15 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/10
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Driver		10b. KIND OF BUSINESS OR Balto. Tran. Co.	9. AGE (In years lost birthday) 56 YRS 11. BIRTHPLACE (State or foreign country) Balto. Co.
13. FATHER'S NAME Herbert E. Francis		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, unknown) Yes		16. SOCIAL SECURITY NO 216 05 7971	
17. INFORMANT Margaret M. Francis		Address 1281 Cedarcroft Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 1129 IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) Coronary Artery Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 3/15/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/67	23c. NAME OF CEMETERY OR CREMATORY Camp Chapel Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home		25a. RECEIVED BY REGISTRAR MAR 17 1967	
Address 7401 Belair Road		25b. REGISTRAR'S SIGNATURE Charles F. O'Donnell	

03212

CERTIFICATE OF DEATH

03204

1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Nursing Home		d. STREET ADDRESS 104 Croydon Road 2111	
3. NAME OF DECEASED (Type or print) First Carolyn Estelle Middle Fritz Last Fritz		4. DATE OF DEATH Month March Day 30th. Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1907
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months 12 Days 2 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Joseph H. Griffie		14. MOTHER'S MAIDEN NAME Elmira Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-36-0841	
17. INFORMANT Mr. Robert D. Fritz		Address 119 Hedgewood Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive pneumothorax			INTERVAL BETWEEN ONSET AND DEATH 12 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1955 , to March 1967 , that (I) (we) last saw the deceased alive on March 1967 , and that death occurred at 3:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Fredrick J. Vollmer		22b. DATE SIGNED 3/30/67	
22c. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER		22d. ADDRESS 6100 YORK RD BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/1967	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	23d. LOCATION (City or Town) (County) (State) Woodlawn, Md.
24. FUNERAL DIRECTOR Wm. J. Trakner & Sons Inc.		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

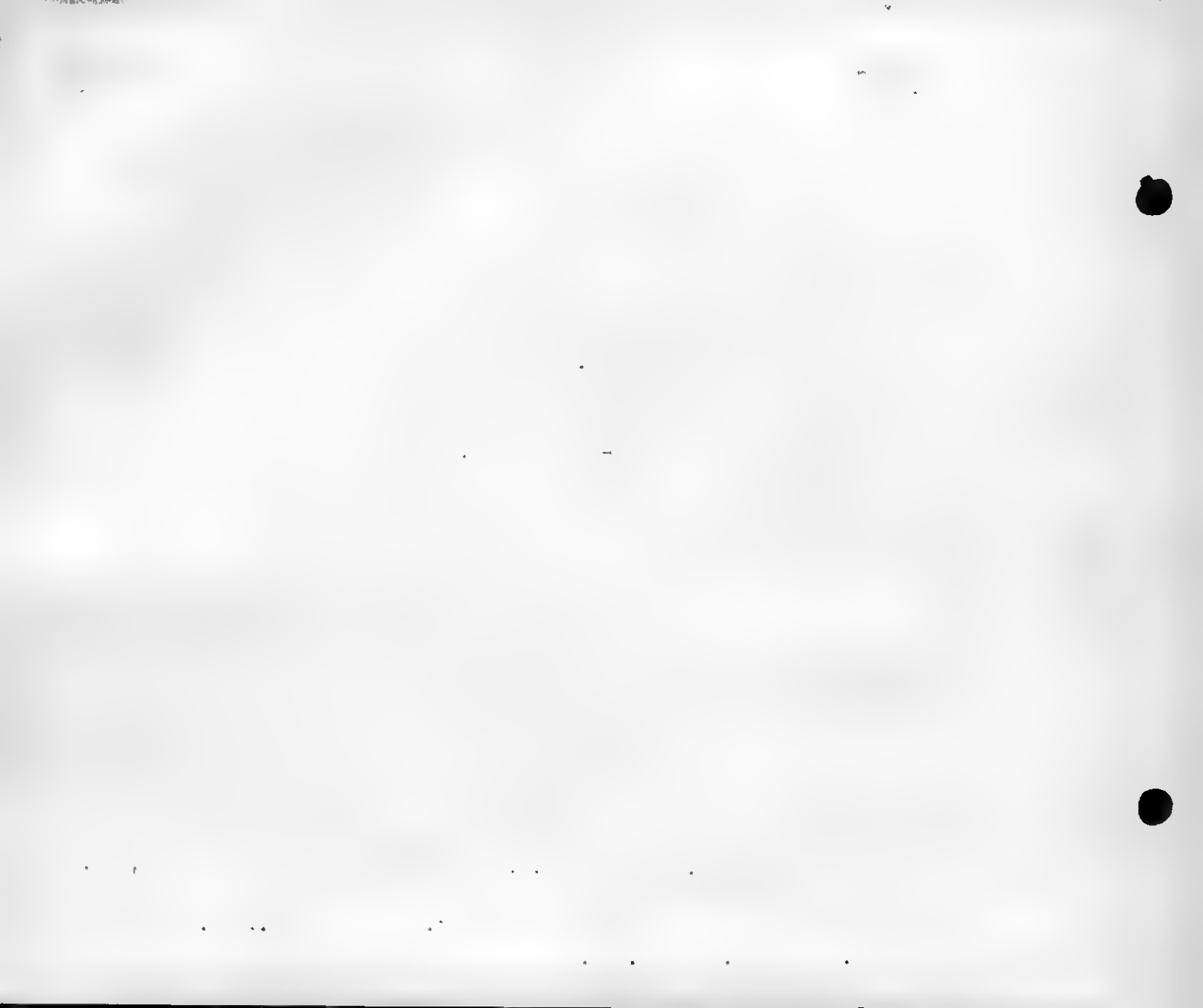
03205

03213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 8709 Baker Avenue	
3. NAME OF DECEASED (Type or print) Jennie		4. DATE OF DEATH Month March Day 28 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home.	9. AGE (in years last birthday) 70 yrs
11. BIRTHPLACE (County & State, or foreign country) Italy		12. COUNTRY OF BIRTH Sicily, Italy	
13. FATHER'S NAME Joseph Cantale		14. MOTHER'S MAIDEN NAME Mary Carmeci	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 214-18-2983	
17. INFORMANT Mrs. Concetta Lang		Address same	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular thrombosis or hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 27, 19 67 to March 28, 19 67 , that (I) (we) last saw the deceased alive on March 28, 19 67 , and that death occurred at 6:25 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Efraim L. Reyes M.D.</i>		22b. DATE SIGNED March 28, 1967	
22c. PHYSICIAN'S NAME (Type) Efraim L. Reyes M.D.		22d. ADDRESS 7620 York Road-Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	23d. LOCATION (City or Town) (County) (State) Balto., Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a. REC'D BY REGISTRAR MAR 30 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

03214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03206

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
c. LENGTH OF STAY IN 1b Hours		d. STREET ADDRESS 14 E. Seminary Ave. 21093	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Stephen Boyd Galloway		4 DATE OF DEATH Month March Day 17 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct, 12, 1953
9 AGE (In years last birthday) 13 yrs		10 IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Mins 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME T. Merrill Galloway		14. MOTHER'S MAIDEN NAME Audrey Schultz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT Mr. T. Merrill Galloway		Address 14 E. Seminary Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Abdominal Hemorrhage DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) For Multiple Soft Tissue Trauma DUE TO (c) Depressed Fracture Occiput (Rt)		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by automobile	
20c. TIME OF INJURY Month, Day, Year Hour am 9:20 pm March 17 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street	20f. (City or town) (County) (State) Lutherville Balto. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		22. DATE SIGNED 3/17/67	
EXAMINER'S NAME (Type) CHAREES F. O'DONNELL, M.D.		Address (Street, city, town, or county) Cockeysville, Md.	
23a. BURIAL CREMATORY, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/21/67	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Cockeysville Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR MAR 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only death is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03215

03207

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALD. MEDICAL CENTER

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE
d. STREET ADDRESS 3807 SEVEN MILE LANE

3. NAME OF DECEASED (Type or print) LILY E. GAMSE
4. DATE OF DEATH MARCH 30 1967

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 8-7-87
9. AGE (In years less birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (State or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Herman Jansen 14. MOTHER'S MAIDEN NAME Olga Wolfson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO UNKNOWN 17. INFORMANT Mrs. Jenny Hoffman, 2825 W. Strathmore Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
(b) PULMONARY EMBOLISM
(c) FRACTURE, RIGHT HIP
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FELL AT HOME

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH ☒ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18) FELL AT HOME

20c. TIME OF INJURY Month, Day Year FEB 7 1967 20d. INJURY OCCURRED While ☐ Not While ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME 20f. (City or town) PIKESVILLE (County) BALTO. (State) MD.

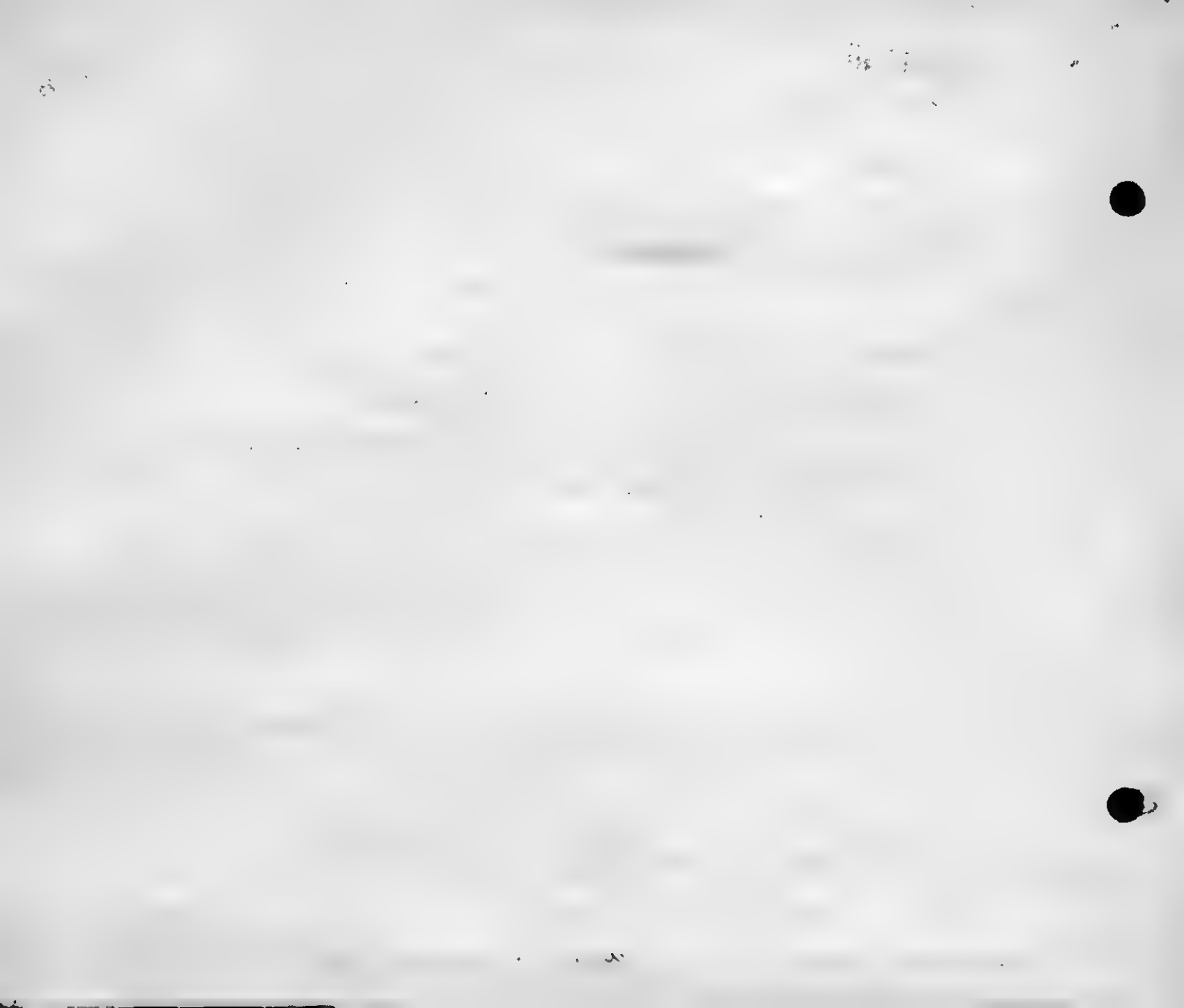
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE William A. Pillsbury CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 3/30/67
Address (Street, city, town, or county) BALTIMORE

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/31/67 22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew 22d. LOCATION (City, town, or country) Baltimore, Maryland

23. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd. 24a. REC'D BY REGISTRAR APR 5 1967 24b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



03216

CERTIFICATE OF DEATH

03208

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>11 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forrest Haven Nursing Home, Catonsville,</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>	
3 NAME OF DECEASED (Type or print) <u>Howard Ernest Gardner</u>		4 DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1957</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1893</u>
9 AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidated Engineering Pikesville, Md.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Dell Blakeley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>none</u>		16 SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Mrs. Helen M. Hartley, 509 Milford Mill Rd.</u>		Address <u>Pikesville 5, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HELVETIC POLIOMYELITIS</u> 4221 DUE TO <u>HELVETIC POLIOMYELITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE PARALYSIS</u> DUE TO <u>ACUTE PARALYSIS</u> (c) <u>ACUTE PARALYSIS</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>56</u> , to <u>3-13</u> , 19 <u>57</u> , that (I) (we) last saw the deceased alive on <u> </u> 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Shaw M.D.</u>		22b. DATE SIGNED <u>3/17/57</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>		22d. ADDRESS <u>506 E. Main St. Pikesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 11, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gruid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03217

CERTIFICATE OF DEATH

03209

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN lb 10 mos.		d. STREET ADDRESS 1908 Hillcrest Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Rochester Glenn		4. DATE OF DEATH Month Day Year March 19 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1883
9. AGE (In years last birthday) 83		10. BIRTHPLACE (County & State, or foreign country) Rock Hall, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Spinner		11. BIRTHPLACE (County & State, or foreign country) Rock Hall, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Glenn	
14. MOTHER'S MAIDEN NAME Georgiana Lant		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT William J. Glenn - 1908 Hillcrest Rd. #7	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arterial sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hr ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar 2, 1967 to Mar 19, 1967 that (I) (we) last saw the deceased alive on Mar 17, 1967 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Wm. E. Martin		22b. DATE SIGNED Mar 19, 1967	
22c. PHYSICIAN'S NAME (Type) Wm. E. Martin		22d. ADDRESS Randallstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-22-67	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery	23d. LOCATION (City or Town) (County) (State) Arcadia, Maryland
24. FUNERAL DIRECTOR Ellsworth Armacost		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 21 1967	



03218

CERTIFICATE OF DEATH

03210

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>4907 Queensberry Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore Co. Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Simon</u> Middle <u>Goldberg</u> Last <u>Goldberg</u>		4 DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>CAU</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/21/1900</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Maker (Factory)</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ARON Goldberg</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-9728</u>	
17. INFORMANT <u>Mrs. Sally Krieger, 6908 Dorsett Place</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart</u> DUE TO (b) <u>Heart</u> DUE TO (c) <u>Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>1967</u> , and that death occurred at <u>1967</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shaarei Zion</u>		23d. LOCATION (City or Town) (County) (State) <u>Rosedale, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

03219

CERTIFICATE OF DEATH

03211

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c LENGTH OF STAY IN 1b 9 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d STREET ADDRESS Town Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Grover Middle C. Last Gonce				4 DATE OF DEATH Month March Day 4 Year 19 67				
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Mar 2, 1902		
9. AGE (in years lost birthday) yrs 65		IF UNDER 1 YEAR Months 6 Days 5		IF UNDER 24 HRS Hours 5 Min. 40				
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10b KIND OF BUSINESS OR INDUSTRY farm		11 BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William Gonce				14. MOTHER'S MAIDEN NAME Lida Lofland				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 221-20-8351		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 9:40		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that PA (this hospital) attended the deceased from Feb. 25, 19 67 to March 4, 19 67 that PA (we) last saw the deceased alive on March 4, 19 67 , and that death occurred at 9:40 M., from causes on and on the date stated above.								
22a. SIGNATURE <i>Stella Wachslar</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-6-67		
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF Mar 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Townsend Cem.		23d. LOCATION (City or Town) (County) (State) Townsend N.C. 1306		
24. FUNERAL DIRECTOR <i>Heck Home for Funerals, Elkton, Md.</i>				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

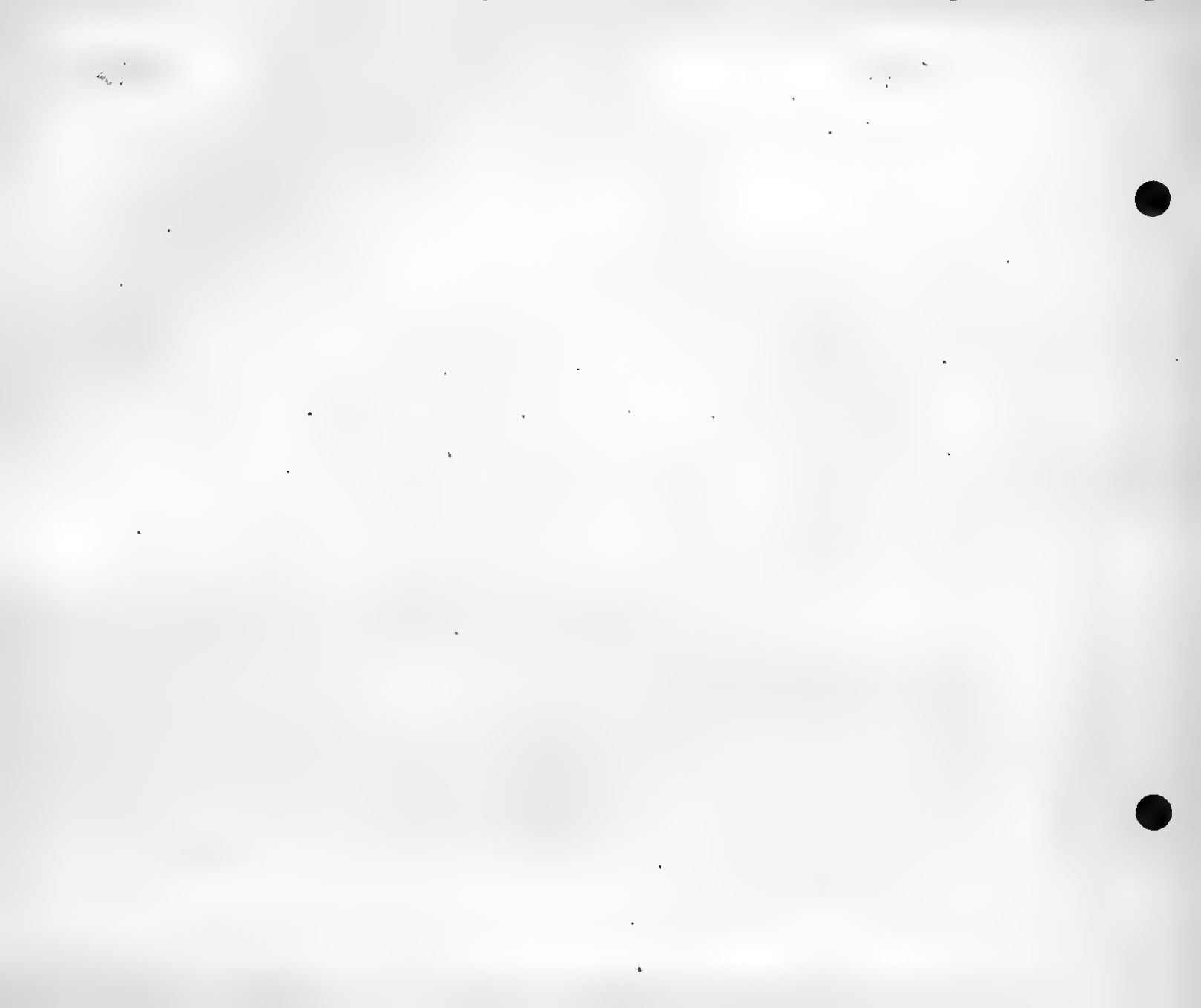
03220

03213

1. PLACE OF DEATH a. COUNTY GBMC Balt. County		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Constance S. Graleska		4. DATE OF DEATH 3 13 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
SECRETARY		C.I.A. Wash. D.C.	Baltimore, Md
13. FATHER'S NAME Joseph Graleska (dec)		14. MOTHER'S MAIDEN NAME Jeliowski (de)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-16-1666	17. INFORMANT Amelia G. Loreless - 20 Willow Ave
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-21-67 to 3/13, 1967 , that (I) (we) last saw the deceased alive on 3-13 1967 , and that death occurred at 5:00 AM , from the causes and on the date stated above.			
22a. SIGNATURE Ram K. Chhillar		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) RAM K. CHILLAR		22d. ADDRESS GREATER BALTIMORE MED. CENTER BALTIMORE, MD. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3/15/67	Holy Redeemer Cem	Balto. Md.
24. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd.		25a. REC'D BY REGISTRAR MAR 16 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03221

CERTIFICATE OF DEATH

03214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 350 ROSE BANK AVE. BALTIMORE	
c. LENGTH OF STAY IN 1b 11 DAYS		d. STREET ADDRESS 350 ROSE BANK AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ROBERT BUSWELL GRANT		4 DATE OF DEATH 3 27 1967	
5 SEX M	6 COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/22 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL ENGINEERING METAL CONSTRUCTIONS		11. BIRTHPLACE (County & State or foreign country) BROOKLYN N.Y. N.Y.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT J. GRANT	
14. MOTHER'S MAIDEN NAME MARY BUSWELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) YES (If yes give war or dates of service) 1942/1945 212-20-725	
16. SOCIAL SECURITY NO. 212-20-725		17. INFORMANT ROBERT J. GRANT Address 328 ST. DOWNS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-15, 1967 , to 3-27, 1967 , that (I) (we) lost saw the deceased alive on 3-26, 1967 , and that death occurred at 6:45 AM , from causes on and on the date stated above.			
22a. SIGNATURE Mario B. Ines M.D.		22b. DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) MARIO B. INES M.D.		22d. ADDRESS GBMC	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/29/1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a. RECD BY REGISTRAR MAR 28 1967	
		25b. REGISTRAR'S SIGNATURE J. W. Jenkins	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03222

CERTIFICATE OF DEATH

03215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 29</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 29</u>	
c. LENGTH OF STAY IN 1b <u>17 Years</u>		d. STREET ADDRESS <u>5508 Edmondson Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5508 Edmondson Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>FRANK J. GRINES</u>		4 DATE OF DEATH <u>March 4, 1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 29, 1880</u>
9 AGE (In years past birthday) <u>87</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>Carroll Co., Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Grines</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Glennon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO <u>210-18-4514</u>		17 INFORMANT <u>Mrs. Elsie M. Grines</u> Address <u>Same As #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4221 DUE TO (b) <u>A.S.C.U. Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>67</u> , to <u>3/4</u> , 19 <u>67</u> that (I) (was) last saw the deceased alive on <u>3/4</u> , 19 <u>67</u> , and that death occurred at <u>6 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. C. MacLaughlin</u>		22b. DATE SIGNED <u>3/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin</u>		22d. ADDRESS <u>303 N. Rolling Rd. 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/8/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Taylorsville</u>	23d. LOCATION (City or Town) (County) (State) <u>Carroll Co., Md.</u>
24. FUNERAL DIRECTOR <u>C. M. Waltz</u> ADDRESS <u>Box 241 Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 PLACE OF DEATH a COUNTY Baltimore MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore					
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Essex				c LENGTH OF STAY IN It		c CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Essex					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1810 Kitty Hawk Road						d STREET ADDRESS 1810 Kitty Hawk Road				e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MINNIE Middle HELEN Last GRIMES						4 DATE OF DEATH Month March Day 30 Year 19 67					
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 11, 1926		9 AGE (In years last birthday) 40 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator				10b. KIND OF BUSINESS OR INDUSTRY Oil Co.		11. BIRTHPLACE (State or foreign country) N.C.			12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Thomas Odom						14. MOTHER'S MAIDEN NAME Bertie Strickland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOC. SEC. NO. 40-20-7765		17 INFORMANT Address Peggy Grimes 1915 Synder Ave. Balto, Md. 22					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra-Abdominal hemorrhage DUE TO (b) Laceration of liver DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Beaten about face, trunk and extremities							
20c TIME OF INJURY Month, Day, Year Hour 4:00 p.m. 3-29 1967				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parking Lot		20f (City or town) (County) (State) Baltimore Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty M.D.						22. DATE SIGNED 3/30/67					
EXAMINER'S NAME (Type) Charles S. Petty						22b. REGISTRAR'S SIGNATURE Charles Judge					
23a BURIAL, CREMATION, REMOVAL, (Specify) Removal				23b DATE THEREOF 4/2/67		23c NAME OF CEMETERY OR CREMATORY Gay-Yost Funeral Home		23d LOCATION (City or Town) (County) (State) Rocky Mount, N. C.			
24 FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave. 21						25a REC'D BY REGISTRAR DATE APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03224

CERTIFICATE OF DEATH

03217

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b Halethorpe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1403 Avon Court		d. STREET ADDRESS 1403 Avon Court	
3 NAME OF DECEASED (Type or print) DOROTHY A. GRIMM		4 DATE OF DEATH March 5, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1909
9 AGE (In years last b rthday) 57 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CASHIER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira Rager		14. MOTHER'S MAIDEN NAME Ida Barnhart	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 210-0970-49	
17 INFORMANT Mrs. Ida A. Rager, 1403 Avon Court 21227		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Ureteral obstruction metastatic Carcinoma DUE TO (c) Endometrial Carcinoma uterus			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (the hospital) attended the deceased from July 27, 1964 , to March 5, 1967 , that (I) (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 2:30 AM , from causes and on the date stated above			
22a. SIGNATURE A. Bradley Daugherty		22b. DATE SIGNED 3-5-67	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugherty		22d. ADDRESS 1264 Francis Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-8-1967	23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery	23d. LOCATION (City or Town) (County) (State) Westmont, Johnston Penna.
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR MAR 6 1967	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03225

03218

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c LENGTH OF STAY IN 1b 1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Baltimore 21206 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d STREET ADDRESS 5600 Gardenville Ave. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Matthew James GUERIN		4. DATE OF DEATH Month March Day 1 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1884
9. AGE (In years last birthday) 82 yrs.	10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Stationery Engineer	10b KIND OF BUSINESS OR INDUSTRY Continental Oil Co.	11 BIRTHPLACE (County & State, or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Matthew Guerin	
14 MOTHER'S M.A.DEN NAME Margaret Lyons		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 213-05-3965		17. INFORMANT Address Mary Guerin, wife, above (nee Freyer)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Recurrent Myocardial Infarction DUE TO (c) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that 20 (this hospital) attended the deceased from 2/24/ 19 67 , to 3/1/ 19 67 , that OK (we) last saw the deceased alive on 3/1/ 19 67 , and that death occurred at 3:45 P., from causes and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik, M.D.		22b. DATE SIGNED March 1, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial	23b. DATE THEREOF 3/4/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13		25a. REC'D BY REGISTRAR DATE MAR 3 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

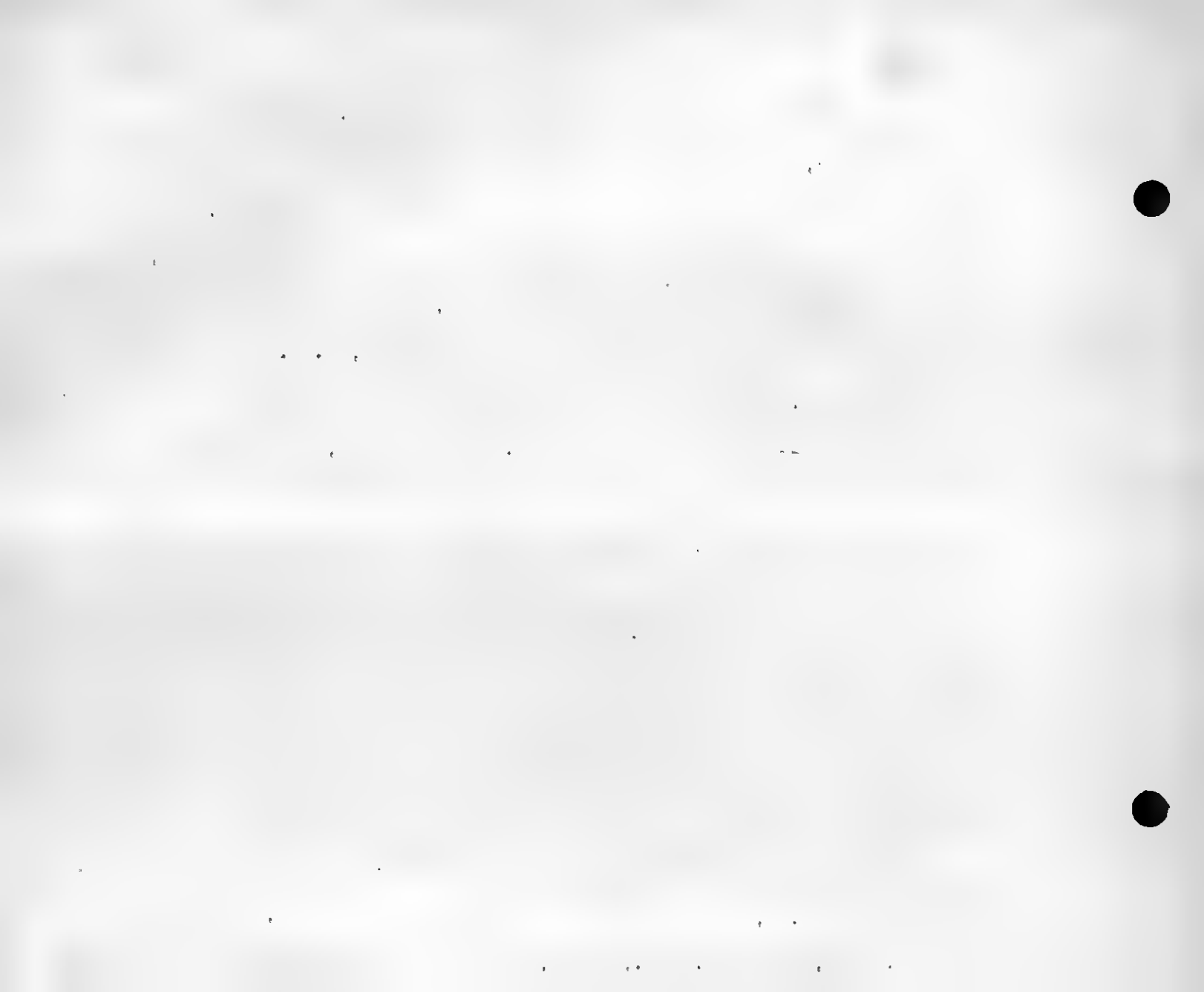
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3226

CERTIFICATE OF DEATH

03219

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. 15146 b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville,		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House of Pines Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monroeville	
f. STREET ADDRESS 422 Fieldstone Dr.		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Hanzlik		4. DATE OF DEATH Month March Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1916
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur E. Maccubbin		14. MOTHER'S MAIDEN NAME Emma Flester	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mr. Henry Hanzlik,		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Ch. Myocarditis DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) multisystemic sclerosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-18, 1965 , to 3-13, 1967 , that (I) (we) last saw the deceased alive on 3-13-1967 , and that death occurred at 4:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE William K. Gallagher Sr.		22b. DATE SIGNED 3-13-67	
22c. PHYSICIAN'S NAME (Type) William K. Gallagher Sr.		22d. ADDRESS 6229 Frederick Ave. Balt. 21228 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Mar. 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION (City, town or county) (State) Laurel, Maryland	
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR MAR 14 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03227

CERTIFICATE OF DEATH

03228

1 PLACE OF DEATH a. COUNTY Baltimore				2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 21206			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 5700 East Ave			
3 NAME OF DECEASED (Type or print) John				4. DATE OF DEATH Month March Day 19 Year 1967			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH October 22, 1887	
9 AGE (In years lost birthday) yrs. 79		IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Products	
11 BIRTHPLACE (County & State, or foreign country) Austria				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Harant				14. MOTHER'S MAIDEN NAME Theresa Unk			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 216-05-3113		17. INFORMANT Address Philip Harant 5807 Sefton Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Gastro Enteritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Dehydration DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1967 to March 19, 1967 , that (I) (we) last saw the deceased alive on March 19, 1967 , and that death occurred at 1:30 M, from causes and on the date stated above.							
22a. SIGNATURE Regalado T. Dizon M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 19, 1967	
22c. PHYSICIAN'S NAME (Type) Regalado T. Dizon M.D.				22d. ADDRESS 7620 York Rd. Towson 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) 4430 Belair Road Md	
24. FUNERAL DIRECTOR The Dippel Brothers Inc 7110 Belair Road				25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03228

CERTIFICATE OF DEATH

03221

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville c. LENGTH OF STAY IN 1b 35 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2815 Garnet Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville d. STREET ADDRESS 2815 Garnet Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle N. Last Harple		4. DATE OF DEATH Month 3 Day 13 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1912	9. AGE (In years last birthday) 55 yrs.	10. FUNERAL 1 YEAR Months 13 Days 13 Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Capt. Fire Dept.		10b. KIND OF BUSINESS OR INDUSTRY Fire Dept.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John C. Harple		14. MOTHER'S MAIDEN NAME Christina Schlissler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-01-1531		17. INFORMANT Alma M. Henning Address Sane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis T-X-01 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 15 minutes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 3-13 , 1967, that (I) (we) last saw the deceased alive on 3-10 , 1967, and that death occurred at 2:30 M, from the causes and on the date stated above.		22a. SIGNATURE Harold H. Burns		22b. DATE SIGNED 3-15-1967	
22c. PHYSICIAN'S NAME (Type) Harold H. Burns		22d. ADDRESS 8106 Harford Road		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-16-1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore	
23d. LOCATION (City, town or county) Baltimore		23e. (State) Md.		24. FUNERAL DIRECTOR Chas. F. Evans & Son ADDRESS 8802 Harford Rd	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 17 1967	

03229

CERTIFICATE OF DEATH

03222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 1332 N. EDEN ST.	
3. NAME OF DECEASED (Type or print) FOREST HARRIS		4. DATE OF DEATH 3 Month 12 Day 19 Year 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/5/98
9. AGE (In years (last birthday) yrs. 68)		IF UNDER 1 YEAR: Months 12 Days 12 Hours 12 Min. 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (County & State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME SARAH CUNNINGHAM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 228-16-7371	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO Second degree A-V Block (b) Coronary Artery Heart Disease DUE TO Coronary Artery Heart Disease (c) Coronary Artery Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. COVD		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 Cases - Vascular Accident, old P.D. taken		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 66 to 3-12 , 19 67 , that (I) (we) last saw the deceased alive on 3/12 , 19 67 , and that death occurred at 5:08 M, from causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer, M.D., Superintendent		22b. DATE SIGNED 3/12/67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Anne Arundel Cty., Md.	
24. FUNERAL DIRECTOR William C. March		25. REC'D BY REGISTRAR DATE MAR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 928 E. North Ave.	

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03230

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03223

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 1 year d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel d. STREET ADDRESS 7602 Brooklyn Bridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Teresa Middle Lynn Last HAYWOOD		4. DATE OF DEATH Month 3 Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years last birthday) 5 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Cumberland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noel Haywood		14. MOTHER'S MAIDEN NAME ORNDORFF, Patricia Ann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood Records		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Gastric & urinary bladder distension DUE TO (c) & Fecal impaction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Institutionalization due to Cervicertus INTERVAL BETWEEN ONSET AND DEATH Terminal Terminal			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 3-10 , 1966, to 3-10 , 1967, that (we) last saw the deceased alive on 3-10 , 1967, and that death occurred at 11:33 AM , from the causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 10 Mar 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/67	23c. NAME OF CEMETERY OR CREMATORY St. Peters	23d. LOCATION (City, town or county) (State) Westernport, Md.
24. FUNERAL DIRECTOR Edw. B. Bial		25a. REC'D BY REGISTRAR MAR 13 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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کتابخانه عمومی
مجلس شورای اسلامی
تهران

کتابخانه عمومی
مجلس شورای اسلامی

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03231

CERTIFICATE OF DEATH

03224

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale 21207		c. LENGTH OF STAY IN TB Rockdale 21207	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3526 St. James Road		d. STREET ADDRESS 3526 St. James Rd.	
3 NAME OF DECEASED (Type or print) C. McLean Hayworth		4. DATE OF DEATH Month March Day 5 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1900
9 AGE (n years last birthday) 66 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Transit	
11 BIRTHPLACE (County & State or foreign country) Blue Island, Cooks Co. Ill.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Walter Hayworth		14 MOTHER'S MAIDEN NAME Lillie May Shoppert	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 213-25-9228	
17 INFORMANT Mrs. Mary E. Hayworth-3526 St. James Rd.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure DUE TO Acute lobular pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lobular pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3/5/67 3/1/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/1/67 , 19 67 , that (I) (we) last saw the deceased alive on 3/5 , 1967, and that death occurred at 2:45 A.M. from causes and on the date stated above			
22a. SIGNATURE Benjamin Siegel		22b. DATE SIGNED 3/7/67	
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin Siegel		22d. ADDRESS 15 Greenwood Rd. Balt., Md. 21208	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/8/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive	23d. LOCATION (City or Town) (County) (State) Randallstown, Md. 21133
24. FUNERAL DIRECTOR Loring Byers-8728 Libert		25a. REC'D BY REGISTRAR MAR 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1958
C. 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03232

CERTIFICATE OF DEATH

03225

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>		c LENGTH OF STAY IN TB <u>17 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Medical Baltimore Center</u>		d STREET ADDRESS <u>215 Sandee Road</u>	
3 NAME OF DECEASED (Type or print) <u>Pauline</u> First <u>H</u> Middle <u>HAZEL</u> Last		4 DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-25-88</u>
9 AGE (In years last birthday) <u>84</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Retired</u>		12 KIND OF BUSINESS OR INDUSTRY <u> </u>	
13 BIRTHPLACE (County & State, or foreign country) <u>ATLANTA, GA.</u>		14 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15 FATHER'S NAME <u>Adison</u> <u>Hook</u>		16 MOTHER'S MAIDEN NAME <u>Sallie Isabelle Lake</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		18 SOCIAL SECURITY NO <u>215-18-7509</u>	
19 INFORMANT <u>Paul H King</u> Address <u>Same as #2</u>		20 PATIENT'S CHART <u>2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Emphysema - putrefactive type - of the Liver</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/14</u> , 19 <u>67</u> , to <u>3/30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/30</u> , 19 <u>67</u> , and that death occurred at <u>12:15 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Derek A Bruce</u>		22b DATE SIGNED <u>3/30/67</u>	
22c PHYSICIAN'S NAME (Type) <u>DEREK. A. BRUCE.</u>		22d ADDRESS <u>G. B. M.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>4-3-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d LOCATION (City or Town) (County) (State) <u>Parkville, Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>		25a REC'D BY REGISTRAR <u>APR 3 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03233

CERTIFICATE OF DEATH

03226

1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Res dence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. LENGTH OF STAY IN 1b Parkville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8312 Overmont Road		d. STREET ADDRESS 8312 Overmont Road	
3. NAME OF DECEASED (Type or print) GRACE R HEILMAN		4. DATE OF DEATH Month 3 Day 26 Year 67	
5 SEX f	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/30/1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office clerk retired		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 83 yrs
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Switzer		14. MOTHER'S MAIDEN NAME Catherine Duval	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219-01-4846	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of left breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio-sclerosis, chronic myocarditis			19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to 3/26/67 , 19, that (I) (we) last saw the deceased alive on 3/25/67 19, and that death occurred at 2 A M, from causes and on the date stated above.			
22a. SIGNATURE A. Calas		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Andres E Callas		22d. ADDRESS 6411 Frederick Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk Parkville, Balto. Co. Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR CHAS. F. EVANS & SON 8802 Harford Rd		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

03227

03234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson (rural) c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if instit' on; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson (rural) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1637 Mussula Road...21204		d. STREET ADDRESS 1637 Mussula Road--21204	
3. NAME OF DECEASED (Type or print) HENRY A. HEMING First Middle Last		4. DATE OF DEATH March 27 1967 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1877. 9. AGE (In years and birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationary Eng.		10b. KIND OF BUSINESS OR INDUSTRY American Smelting Co. Holland	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Heming		14. MOTHER'S MAIDEN NAME Katherine ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-10-1472	
17. INFORMANT Mrs. Catherine B. Heming Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 40-21 DUE TO (b) 40-21 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 40-21			INTERVAL BETWEEN ONSET AND DEATH 4-21
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic renal disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 27, 1967 , to March 27, 1967 , that (I) (we) last saw the deceased alive on March 27, 1967 , and that death occurred at 10:00 M, from causes on and on the date stated above.			
22a. SIGNATURE Dr. Joseph F. LiPira		22b. DATE SIGNED March 28, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Joseph F. LiPira		22d. ADDRESS 8400 Loch Raven Blvd., 21204	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/30/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Baltimore, Md.--21214		25a. REC'D BY REGISTRAR Charles J. J...	25b. REGISTRAR'S SIGNATURE Charles J. J...

MAR 28 1967

3-10-19



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03228

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7108 Plymouth Road		d. STREET ADDRESS 7108 Plymouth Road	
3 NAME OF DECEASED (Type or print) IRENE J. Heretick		4 DATE OF DEATH Month March Day 2 Year 1967	
SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/27/08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical records		10b. KIND OF BUSINESS OR INDUSTRY Seton Institute	9. AGE (In years last birthday) yrs 58
11 BIRTHPLACE (State or foreign country) Homeville, Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William J. Heretick		14 MOTHER'S MAIDEN NAME Margaret A. Hucin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) no		16 SOCIAL SECURITY NO unknown	
17 INFORMANT Miss Otilia Heretick, 7108 Plymouth Road, Pikesville 8, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Gunshot wounds of chest DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot by unknown assailant	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? pm 3/2/ 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> At work <input checked="" type="checkbox"/> At home <input checked="" type="checkbox"/>	20f. (City or town) (County) (State) Pikesville, Baltimore, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED March 3, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		Address (Street, city, town, or county) Pikesville 8, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 6, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery	23d. LOCATION (City or Town) (County) (State) Pikesville 8, Md.
24 FUNERAL DIRECTOR Frank H. Newell, Pikesville 8, Md.		25 REGISTRATION SIGNATURE Charles Judge	

RECORDED BY REGISTRAR
DATE **MAR 9 1967**

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

no

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03229

1 PLACE OF DEATH a COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix / Towson		c LENGTH OF STAY IN TB 23 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		e STREET ADDRESS Phoenix Road	
3 NAME OF DECEASED (Type or print) First Middle Last Charles W. Hicks		4 DATE OF DEATH Month Day Year March 7 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 10, 1902
9 AGE (In years last birthday) 65 yrs		10 IF UNDER 1 YEAR Months Days Hours Min 19 67	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Asst.		12 INDUSTRY Bendix Radio	
13 BIRTHPLACE (State or foreign country) Lower Makefield, Penn.		14 COUNTRY? U.S.A.	
15 FATHER'S NAME Edward Hicks		16 MOTHER'S MAIDEN NAME Mary Elizabeth Sternberger	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18 SOC. SEC. NO. 578-03-5485	
19 INFORMANT Mrs. M. Hicks		Address Same as #2	
1B CAUSE OF DEATH (Enter only one cause governing for (a), (b), and (c)) PART DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22 DATE SIGNED 3/7/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street city town or county)			
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF March 11, 1967	23c NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery	23d LOCATION (City or town) (County) (State) Texas, Baltimore Ct., Maryland
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson		25 REC'D BY REGISTRAR 1050 York Road	
25 REGISTRAR'S SIGNATURE Charles Judge		26 REGISTRAR'S SIGNATURE 1050 York Road	

03237

CERTIFICATE OF DEATH

03230

1 PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) RANDALLTOWN c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY RANDALLSTOWN c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. d. STREET ADDRESS BOX 148 OLD COURTRD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ARTHUR First R. Middle HIGGS Last		4 DATE OF DEATH Month MARCH Day 27 Year 1967	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/8/82 9 AGE (In years last birthday) 85 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11 BIRTHPLACE (County & State or foreign country) PAGE County, VA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HIGGS-JACOB		14. MOTHER'S MAIDEN NAME PAINTER,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 217-01-3948	
17. INFORMANT Thayer Higgs - M.D. Cary Rte. 2.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 9-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) CORONARY ARTERY DISEASE INTERVAL BETWEEN ONSET AND DEATH 1-2 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/27/67 DOA to 3/27/67 , 19 67 , that (I) (we) last saw the deceased alive on 3/27/67 and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Ronald Berger		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) DR. RONALD BERGER		22d. ADDRESS BALTO. COUNTY HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/30/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City or Town) (County) (State) Randallstown, Md.
24 FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03239

CERTIFICATE OF DEATH

03232

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ROSEWOOD</u>		d. STREET ADDRESS <u>3 Contact Court</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>McKinley III</u> Last <u>Hilliard</u>		4 DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-14-43</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>23</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>N. CAROLINA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William McKinley Hilliard</u>		14. MOTHER'S MAIDEN NAME <u>NANA LeAnne Boges</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Rosewood Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia, orthostatic</u> <u>441X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Institutionalization due to Congenital Mental Deficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 27, 1963</u> , to <u>Mar. 8, 1967</u> , that (we) last saw the deceased alive on <u>Mar. 8, 1967</u> , and that death occurred at <u>8:30 P.M.</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Richard A. Jones</u>		22b. DATE SIGNED <u>19 Mar 67</u>	22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones</u>
22d. ADDRESS <u>Rosewood State Hosp.</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DULANEY VALLEY</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>John G. Connolly Sons</u>		25a. MARY REGISTRATION <u>1967</u>	25b. REGISTRAR'S SIGNATURE <u>John G. Connolly</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03240

CERTIFICATE OF DEATH

03233

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Ring		c. LENGTH OF STAY IN IS Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1109 Mace Avenue		d. STREET ADDRESS 1109 Mace Avenue B/221	
3. NAME OF DECEASED (Type or print) First Helen Middle Elizabeth Last Hilmer		4. DATE OF DEATH Month 3 Day 5 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1876
9. AGE (in years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Wendroth		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-50-9187	
17. INFORMANT Mrs. Barbara Hilmer		Address 1109 Mace Avenue B/221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO Heart failure, chronic, left sided DUE TO Hypertensive cardiovascular disease DUE TO Backward		INTERVAL BETWEEN ONSET AND DEATH 8 hours 10 hrs 11 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 1958 to March 5, 1967 , that (I) was last saw the deceased alive on March 6, 1967 , and that death occurred at 4 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Eugene C. Baumann, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) EUGENE C. BAUMANN		22b. DATE SIGNED 3-6-67	
22d. ADDRESS 413 Eastern Ave., Baltimore Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-8-1967	23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery	23d. LOCATION (City or Town) (County) (State) Golden Ring Baltimore Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR 8 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14.3

14.3





121

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123



03241

CERTIFICATE OF DEATH

03234

1 PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>5408 CLOVER ROAD</u>	
3 NAME OF DECEASED (Type or print) <u>Fannie Hoffman</u>		4. DATE OF DEATH <u>March 5, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH _____
9 AGE (In years last birthday) <u>89</u> yrs		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>HARRY DORUTSKY</u>		14. MOTHER'S MAIDEN NAME <u>PAULA ?</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>UNKNOWN</u>	
17 INFORMANT <u>MR. LEON HOFFMAN</u>		Address <u>3415 WASHINGTON AVENUE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>& hypertension</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>about 15 hrs</u> <u>about 20 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (This hospital) attended the deceased from <u>March 1, 1965</u> to <u>March 4, 1967</u> that (I) (We) last saw the deceased alive on <u>3/4</u> 19 <u>67</u> , and that death occurred at <u>1:30</u> A.M. from causes and on the date stated above			
22a SIGNATURE <u>Dr. Herman Seidel</u>		22b DATE SIGNED <u>March 5/67</u>	
22c PHYSICIAN'S NAME (Type) <u>HERMAN SEIDEL</u>		22d ADDRESS <u>2401 Eutaw Place</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>March 6/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore, MD</u>
24 FUNERAL DIRECTOR <u>Sal Geunon Inc</u>		ADDRESS <u>6010 Reister Rd</u>	
25a REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03242

CERTIFICATE OF DEATH

03235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills,		c. LENGTH OF STAY IN 1b Plum Point	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS Box 265 Huntington Rd.,	
3. NAME OF DECEASED (Type or print) First Cleveland Middle Matthew Last Holland		4. DATE OF DEATH Month 3 Day 11 Year 1967	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/16/61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Calvert Co. Hosp.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew C. Holland		14. MOTHER'S MAIDEN NAME Jones, Doris Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO -----	
17. INFORMANT Rosewood Records		Address Owings Mill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic Meningo encephalomyelitis due to staphylococcus DUE TO (c) Chronic Meningo encephalomyelitis due to staphylococcus			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (at) (this hospital) attended the deceased from Feb. 7 , 19 63 , to Mar. 11, 1967 , that (he) (we) last saw the deceased alive on March 11, 1967 , and that death occurred at 10:20 AM , from causes on and on the date stated above			
22a. SIGNATURE Lucrecia F. Joven		22b. DATE SIGNED Mar. 11, 1967	
22c. PHYSICIAN'S NAME (Type) Lucrecia F. Joven M.D.		22d. ADDRESS Rosewood State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-14-67	23c. NAME OF CEMETERY OR CREMATORY Plum Point Church	23d. LOCATION (City or Town) (County) (State) Plum Point Calvert Md.
24. FUNERAL DIRECTOR Joseph E. Berry-Huntington		25. REC'D BY REGISTRAR MAR 14 1967	
26. REGISTRAR'S SIGNATURE John J. Berry		27. REGISTRAR'S SIGNATURE John J. Berry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G374761 DC

03243

CERTIFICATE OF DEATH

03236

1 PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 2 yrs 7 mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills,		d. STREET ADDRESS Juniper Grove Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in The Pines - 15 FUSTING Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First LAWRENCE Middle F. Last HOLLAND		4 DATE OF DEATH Month 3 Day - Year 1967	
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23 1891
9 AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 3 Days 1 Hours 24 Mins 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lin Decorating Co.		10b. KIND OF BUSINESS OR INDUSTRY Art Depl.	
11. BIRTHPLACE (County & State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Holland		14. MOTHER'S MAIDEN NAME Elizabeth Barbie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes World War I		16. SOCIAL SECURITY NO. —	
17. INFORMANT Alan L. McGehee		Address Owings Mills	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) 10 yr		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-26-1964 , to 3-31-1967 , that (I) (we) last saw the deceased alive on 3-31-1967 , and that death occurred at 2:30 PM , from causes and on the date stated above			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED 4-1-67	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.		22d. ADDRESS 6207 Frederick Ave Baltimore 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Balto Md.	
24. FUNERAL DIRECTOR Henry J. Ehrhardt		25a. READ BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge			

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we shall consider the case of a single particle. We shall assume that the particle is moving in a potential field. The Hamiltonian of the system is given by

$$H = \frac{p^2}{2m} + V(x)$$

where p is the momentum, m is the mass, and $V(x)$ is the potential energy. The wave function $\psi(x)$ satisfies the Schrödinger equation

$$H\psi = E\psi$$

where E is the energy. The wave function is normalized so that

$$\int_{-\infty}^{\infty} |\psi(x)|^2 dx = 1$$

3. The third part of the paper is devoted to a discussion of the results.

03244

CERTIFICATE OF DEATH

03237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE New Jersey b. COUNTY Union ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater Lutherville		c. LENGTH OF STAY IN 1b 3 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor Seminary Ave.		d. STREET ADDRESS One Euclid Ave	
3. NAME OF DECEASED (Type or print) Laura Everett Hood		4. DATE OF DEATH March 22 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin A. Bentley		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ???	
17. INFORMANT Walter B. Everett, 11 River Glen Road, Hastings on the Hudson, N.Y.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 301X DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 10, 1960 to March 22, 1967 , that (I) (we) last saw the deceased alive on March 7, 1967 , and that death occurred at 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) Laurence C. Post, M. D.		22d. ADDRESS 6805 York Road, Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Mar. 25 1967	23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	23d. LOCATION (City or Town) (County) (State) Elizabeth, New Jersey
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25. REC'D BY REGISTRAR MAR 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

03245

CERTIFICATE OF DEATH

03238

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. LENGTH OF STAY IN 1b Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2904 Cub Hill Road		d. STREET ADDRESS 2904 Cub Hill Road	
3. NAME OF DECEASED (Type or print) FLORENCE MAE HOOPER		4. DATE OF DEATH Month March Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1880.
9. AGE (In years last birthday) yrs 86		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Beedle		14. MOTHER'S MAIDEN NAME Georgiana G. Waldtjen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-09-1204D	
17. INFORMANT Mrs. Gertrude Welsh		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO Coronary Failure (b) Arteriosclerotic C.V.D. DUE TO Generalized metastatic malignancy (c) Primary site Breast.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1967 , to Mar 15, 1967 that (I) (we) lost saw the deceased alive on Mar 15, 1967 , and that death occurred at 11:20 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Willard Applefold M.D.		22b. DATE SIGNED 3/16/67	
22c. PHYSICIAN'S NAME (Type) Willard Applefold		22d. ADDRESS 5901 Park Heights Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/67.	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR MAR 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

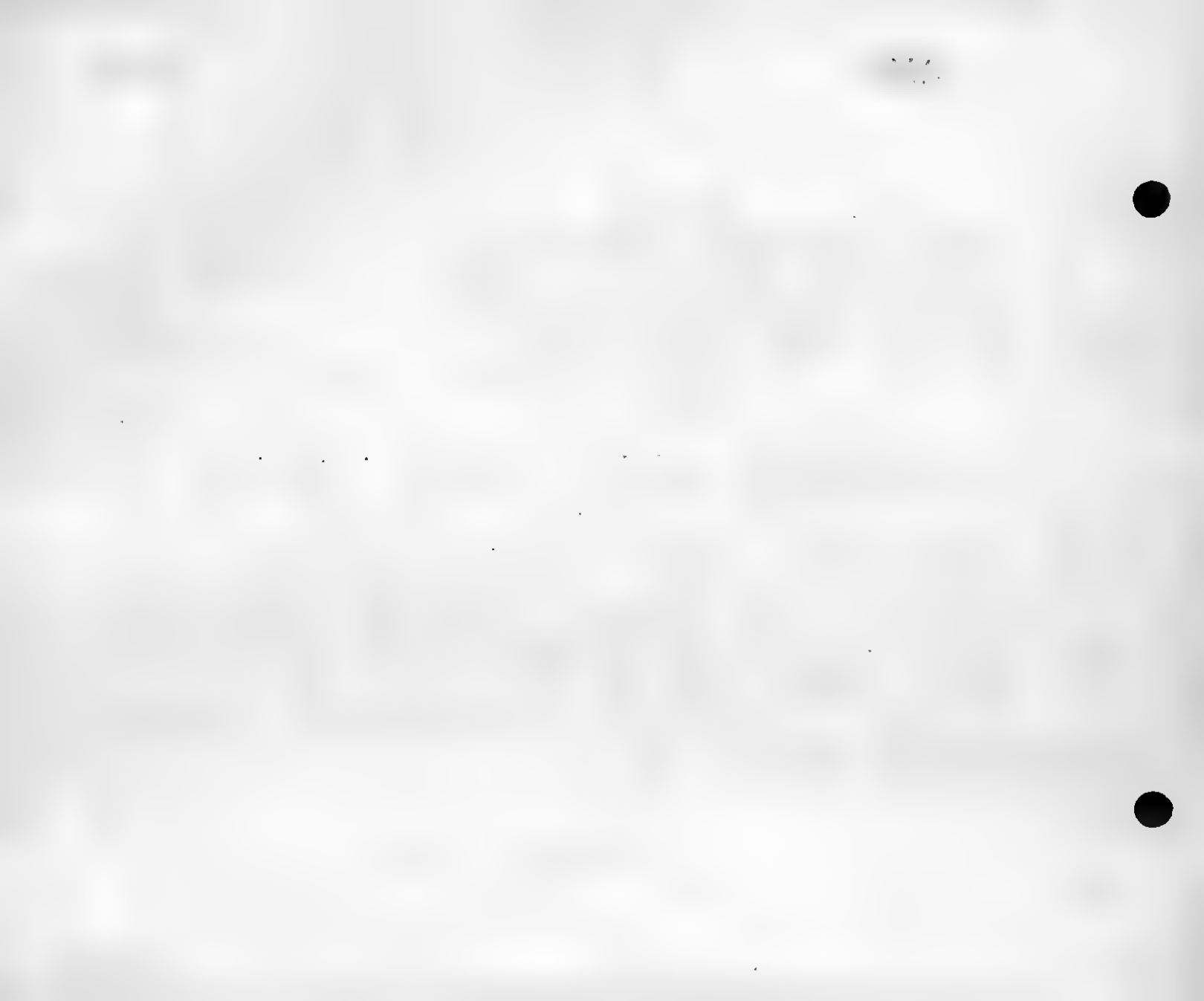
03246

03239

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOME: 621 Chestnut Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> 13-1 d. STREET ADDRESS <u>621 Chestnut Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>STUART</u> Middle <u>CATOR</u> Last <u>HOPPER</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1884</u>	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Samuel W. T. Hopper</u>			14. MOTHER'S MAIDEN NAME <u>Sallie Cator</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW I & II</u>		16. SOCIAL SECURITY NO. <u>215-24-8963</u>		17. INFORMANT: <u>wife</u> Address <u>Towson, 21204</u> <u>Mrs. Henrietta S. Hopper, 621 Chestnut Av.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> (b) <u>Arteriosclerosis</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (a) <u> </u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of prostate</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 years</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1967</u> to <u>March 8, 1967</u> that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> and that death occurred at <u>6:00 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>C. Stuenkel Boyd</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>March 9, 1967</u>		
22c. PHYSICIAN'S NAME (Type) 					22d. ADDRESS 		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Maryland</u> (State) <u> </u>		24. FUNERAL DIRECTOR <u>Stewart & Mowen Co., 100 North Av., Balto.</u> ADDRESS <u>21201</u>					
25a. REC'D BY REGISTRAR <u>Mar 10 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G33 3/3/57 pc

03247

CERTIFICATE OF DEATH

03240

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN TOWN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1133 Crems Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balti</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>1133 Crems Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Arthur H. Hopson</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY		4. DATE OF DEATH <u>Mar-4th</u> 19 <u>67</u> 9. AGE (in years lost birthday) <u>36</u> <u>87</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: Months _____ Days _____ Hours _____ Min _____ 11. BIRTHPLACE (County & State, or foreign country) <u>N Carolina</u> 12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Jason H. Hopson</u> 14. MOTHER'S MAIDEN NAME <u>Nannie A. Troutman (deceased)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>distal atherosclerotic cardiac vasculature</u> DUE TO (b) <u>disease with acute infarction</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>March 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 4</u> , 19 <u>67</u> , and that death occurred at <u>5 P</u> M, from causes and on the date stated above. 22a. SIGNATURE <u>Louis Semeloff</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMELOFF</u> 22d. ADDRESS <u>2108 CREMS RD BALTO 20, MD</u> 22b. DATE SIGNED <u>March 5, 1967</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-7-1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hopson Cemetery</u> 23d. LOCATION (City or Town) (County) (State) <u>Mitchell Co N. Carolina</u>		24. FUNERAL DIRECTOR <u>Connolly Funeral Home - 300 Prince Ave</u> ADDRESS 25a. REC'D BY REGISTRAR <u>MAR 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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03248

CERTIFICATE OF DEATH

03241

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4500 Kenwood Avenue		d. STREET ADDRESS 4500 Kenwood Avenue	
3. NAME OF DECEASED (Type or print) Alice M. Hunt		4. DATE OF DEATH Month 3 Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-1897
9. AGE (In years last birthday) 69 YRS		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State or foreign country) W. Va. Huntington		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 233-07-1169D	
17. INFORMANT Mrs John Mergler 6008 Westwood Avenue 6		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerosis cardio vascular disor DUE TO (c) 3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 30, 1966, to March, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 7:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles M. Kerr M.D.		22b. DATE SIGNED April 10, 1967	
22c. PHYSICIAN'S NAME (Type) Charles M. Kerr		22d. ADDRESS 6801 Belair Rd J B 2 to 6.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-20-1967	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery Baltimore Co. Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Larsen Funeral Home 7401 Belair Road		25a. REC'D BY REGISTRAR DATE 9 20 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03249

CERTIFICATE OF DEATH

03242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County - 28</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 days</u>		d. STREET ADDRESS <u>1225-Hambert St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton-Ridge Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Jacobs</u> Last <u>Jacobs</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1889</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>Valerij Pavlovski</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Kroun</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Julia Kelly</u>		Address <u>1225 Hambert St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD -</u> DUE TO (b) <u>Acute Pyelonephritis -</u> DUE TO (c) <u>Leukemia -</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/6/67, 1967</u> , to <u>3/7/67, 1967</u> , that (I) (we) last saw the deceased alive on <u>3/7/67, 1967</u> , and that death occurred at <u>6:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Anthony M. Allieborg</u>		22b. DATE SIGNED <u>3/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Anthony M. Allieborg</u>		22d. ADDRESS <u>8155 Loch Raven Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glenn Haven Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Arundel, Md.</u>
24. FUNERAL DIRECTOR <u>Charles L. Stevens Funeral Home, Inc.</u>		25a. REC'D BY REGISTRAR <u>1501 E. Fort Avenue.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 8 1967</u>	

12



03250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03244				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point c. LENGTH OF STAY IN 1b Hours 77 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plant Dispensary					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 7713 Trappe Rd. #22 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alfred R. JONES					4. DATE OF DEATH Month 3 Day 21 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-09		9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oeys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard work				10b. KIND OF BUSINESS OR INDUSTRY Ship Building		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Jones					14. MOTHER'S MAIDEN NAME Harriett Fairburn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 283-01-9333		17. INFORMANT Wife, Virginia Jones, # 2,a,b,c,d.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion- 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } OUE TO (b) A.S.C.V.D. OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH —	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. N				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE M.B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 3-21-67	
EXAMINER'S NAME (Type) M.B. Davis, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) 6800 Mornington Road Baltimore, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar-25-1967		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222						25a. REC'D BY REGISTRAR MAR 22 1967			
						25b. REGISTRAR'S SIGNATURE J. Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03252

CERTIFICATE OF DEATH

03245

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Homes</u>		d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle _____ Last <u>Jones</u>		4 DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Fe</u> 6 COLOR OR RACE <u>White</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8 DATE OF BIRTH <u>August 14, 1891</u> 9 AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTH PLACE (County & State, or foreign country) <u>Somerset, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>William E. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mary W. Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>220-54-969281</u>	
17. INFORMANT <u>Records of Md. Masonic Homes, Cockeysville</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Brain Syndrome</u> DUE TO (c) <u>Advanced Senility</u>		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1965</u> to <u>Feb 27, 1967</u> that (I) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>12 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jamshid Hamed</u>		22b. DATE SIGNED <u>March 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED</u>		22d. ADDRESS <u>MASONIC HOME</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Marion, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

03246

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside of corporate limits write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>Overlea</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4339 Glenmore Ave.</u>		d. STREET ADDRESS <u>4339 Glenmore Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Marie</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-11-1885</u>
9. AGE (In years last birthday) yrs <u>81</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Kaiss</u>		14. MOTHER'S MAIDEN NAME <u>Caroline L. Letmate</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220302919</u>	
17. INFORMANT <u>Mrs Ralph Veara</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 7.250 DUE TO <u>A.S.U.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <u>Cerebral Insufficiency</u> (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>240</u> <u>240</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/67</u> , 19 <u>67</u> to <u>3/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/6/67</u> , 19 <u>67</u> , and that death occurred at <u>3:20</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Walter E. Karfain</u>		22b. DATE SIGNED <u>3/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER E. KARFAIN</u>		22d. ADDRESS <u>4331 Harford Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03254

03247

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Hrs. 5Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 114 Third Street	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle L Last JONES		4. DATE OF DEATH Month MARCH Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/08
9. AGE (In years last birthday) 58 yrs		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Security	
11. BIRTHPLACE (County & State, or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles P. Jones		14. MOTHER'S MAIDEN NAME Margaret Grantland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 221-05-86-31	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent Meningitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pneumonia DUE TO (c) Uremia			INTERVAL BETWEEN ONSET AND DEATH Days Days Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 17, 1967 , to March 17, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 17, 1967 , and that death occurred at 10:30 PM from causes and on the date stated above			
22a. SIGNATURE Z. S. Tao		22b. DATE SIGNED 3/19/67	
22c. PHYSICIAN'S NAME (Type) ZUI-SUN TAO		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/24/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Zannino Funeral Home		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>



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03255

CERTIFICATE OF DEATH

03248

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c LENGTH OF STAY IN 1b 21212	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 6702 Glenkirk Avenue	
3 NAME OF DECEASED (Type or print) First Maud Middle Louise Last Kane		4. DATE OF DEATH Month March Day 6 Year 19 67	
5 SEX Female	6 CO. OR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-91
9. AGE (In years last birthday) 16 15 yrs		IF UNDER 1 YEAR Months 16 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State or foreign country) Scranton, Pa.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Edward Burke		14. MOTHER'S MAIDEN NAME Jane Murphy	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 159055257B	
17 INFORMANT Mrs Bernard Norton		Address 6702 Glenkirk Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Core pulmonale DUE TO (b) Severe fibrosis of left lung. DUE TO (c) lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 5, 19 67 to March 6, 19 67 that (I) (we) last saw the deceased alive on March 6, 19 67 , and that death occurred at 2:25AM , from causes and on the date stated above.			
22a. SIGNATURE M.S. Cockburn MD		22b. DATE SIGNED March 6, 1967.	
22c. NAME (Type) M.S. Cockburn, M.D.		22d ADDRESS 7620 York Rd., Baltimore, Md. 21204	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 3-10-67	23c NAME OF CEMETERY OR CREMATORY Holy Sepulcher Cem.	23d. LOCATION (City or Town) (County) (State) Phialdelphia, Penna.
24 FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		25a. REC'D BY REGISTRAR APR 9 1967	25b REGISTRAR'S SIGNATURE J Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
20 M 1/66

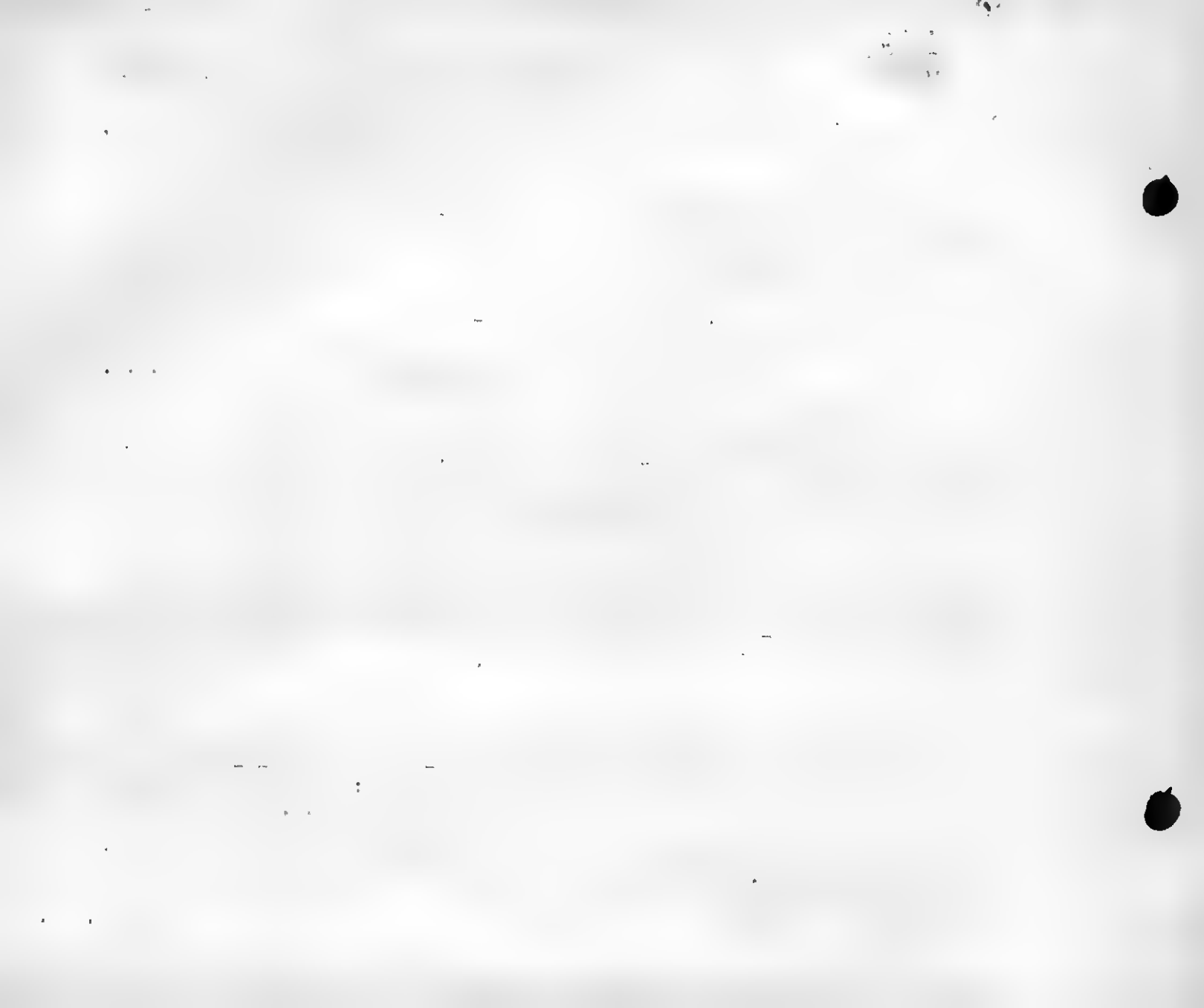
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03256

CERTIFICATE OF DEATH

03249

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS 6307 Hamilton Avenue 21206	
3 NAME OF DECEASED (Type or print) First Amelia Middle Karp Last Karp		4. DATE OF DEATH Month March Day 9 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-82
9 AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11 BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul German		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-54-3179	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Feeding problem - Chronic Brain Syndrome associated with Cerebral Arteriosclerosis with psychotic features.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. (City or town)		20e. (County) (State)	
21. I certify that (this hospital) attended the deceased from 10-11-63 , 19____, to 3-9-67 , 19____, that (we) last saw the deceased alive on 3-9-67 , 19____, and that death occurred at 1:20 M, from causes and on the date stated above			
22a. SIGNATURE <i>Evelio A. Felipe</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe		22d. ADDRESS Spring Grove State Hospital 1 Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-1967	
23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Golden Ring Balto. Md.	
24. FUNERAL DIRECTOR <i>Lawrence F. ...</i>		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03257

03250

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN MARYLAND 51yr5mth23dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1239 Glenhaven Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Margaret Middle Kernan Last Kernan			4. DATE OF DEATH Month March Day 30 Year 1967		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1889	9. AGE (in years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME Michael Kernan			14. MOTHER'S MAIDEN NAME Isabell Ackenback		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-54-3188T	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition - Chronic brain syndrome associated with generalized arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____		
21. I certify that he (this hospital) attended the deceased from Sept. 23, 1965 to March 30, 1967 , that (I) (we) last saw the deceased alive on March 30, 1967 , and that death occurred at 2:45 M, from the causes and on the date stated above.					
22a. SIGNATURE Evelio A. Felipe, M.D.		22b. DATE SIGNED 3-30-67		22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL		22e. ADDRESS Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-31-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore Maryland		
24. FUNERAL DIRECTOR John Cook - Brooks Inc.		ADDRESS 1217 St. Paul Street	25a. REC'D BY REGISTRAR APR 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

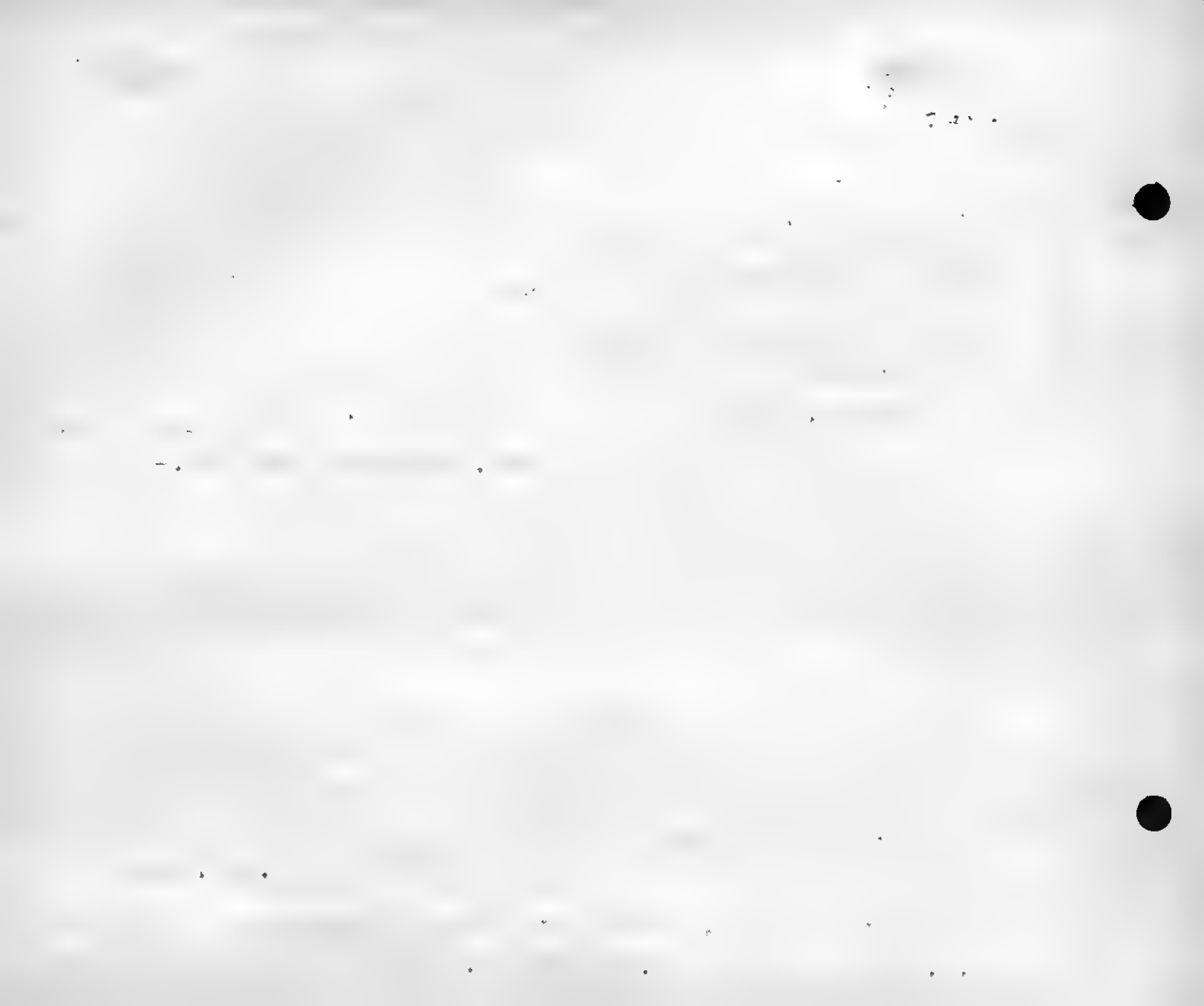
03258

03251

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) G.B.M.C.			d. STREET ADDRESS Loyola High School Charles Street		
3. NAME OF DECEASED (Type or print) Gregory G. Kiehne			4. DATE OF DEATH Month 8 Day 3 Year 1967		
5. SEX M.	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1885		9. Age (in years last birthday) 81 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt. Priest		10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (County & State or foreign country) BALTIMORE, Md.	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME HERMAN H. KIEHNE		
14. MOTHER'S MAIDEN NAME MARY C. NELSON			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT REV. McNAMARA BOYCE AVE. - 21204		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIO-Resp. Failure DUE TO (b) Cancer of Lung DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 2/24/67 , 19 67 , to 3/4/ , 19 67 , that (I) (we) lost saw the deceased alive on 3/4 , 19 67 , and that death occurred at 3:40 AM, from causes on and on the date stated above.					
22a. SIGNATURE Denis Chan		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/4/67	
22c. PHYSICIAN'S NAME (Type) DENIS CHAN. MD		22d. ADDRESS GREATER BALTO. MED. CENTER			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 7/67		23c. NAME OF CEMETERY OR CREMATORY WOODSTOCK COLLEGE	
23d. LOCATION (City or Town) (County) (State) WOODSTOCK BALTIMORE, MD		24. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.		25a. REC'D BY REGISTRAR MAR 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03259

CERTIFICATE OF DEATH

03252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 13-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5464 Addington Road				2 USUAL RESIDENCE (Where deceased lived, if instituton Residence before admission) a. STATE Maryland b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 5464 Addington Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Louis E. Middle Kimmel Last Sr.				4 DATE OF DEATH Month March Day 7 Year 1967			
5 SEX M		6 COLOR OR RACE Wh.		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH June 11 1895	
9 AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS Hours 67 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME John Kimmel				14. MOTHER'S MAIDEN NAME Regina Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louis E. Kimmel Address 5464 Addington Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO-VASCULAR THROMBOSIS. 332X DUE TO (b) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from DEC. , 19 60 , to MARCH 7, 1967 , that (I) (we) las saw the deceased alive on MARCH 6, 1967 , and that death occurred at 3PM , from causes and on the date stated above							
22a. SIGNATURE Norman R. Kleiman				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3/8/67	
22c. PHYSICIAN'S NAME (Type) NORMAN R. KLEIMAN				22d. ADDRESS 3803 EDMONDSON AVE.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03260

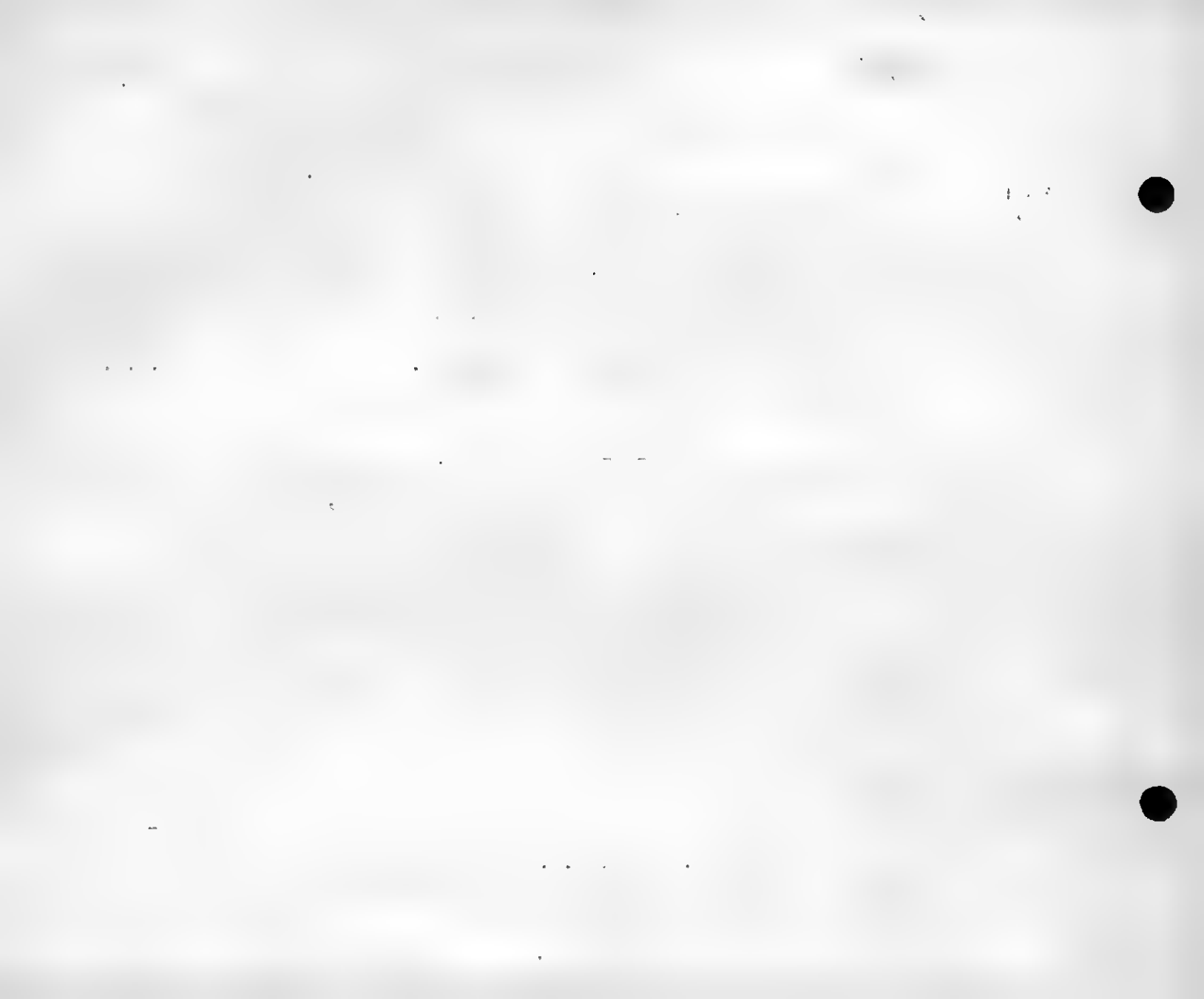
CERTIFICATE OF DEATH

03253

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Landover, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. STREET ADDRESS 7622 Goodland Drive	
3. NAME OF DECEASED (Type or print) First Clarence Middle A. Last Kirker Sr		4. DATE OF DEATH Month March Day 22 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-90
9. AGE (In years last birthday) yrs 77		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brickmason		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Kirker		14. MOTHER'S MAIDEN NAME Margaret	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 579-09--117	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, organism unknown, left lower lobe DUE TO (b) 190X DUE TO (c) lobes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure			
19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he/she) attended the deceased from 11-1-66 , 19 to March 22, 1967 , that (he/she) last saw the deceased alive on March 22, 1967 , and that death occurred at 7:45 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 3-22-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 25, 1967	
23c. NAME OF CEMETERY OR CREMATORY Nt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D C	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03261 CERTIFICATE OF DEATH 03251

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	
c. LENGTH OF STAY IN TB <u>20 years</u>		d. STREET ADDRESS <u>1955 Walnut Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1955 Walnut Avenue</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT J. KOWALSKI</u>		4. DATE OF DEATH Month Day Year <u>March 18, 1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>11/22/1917</u>		9. AGE (In years last birthday) <u>49 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship Repair</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Kowalski</u>		14. MOTHER'S MAIDEN NAME <u>Victoria ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>216-05-9072</u>	
17. INFORMANT <u>Mrs. Elizabeth Kowalski, 1955 Walnut Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> DUE TO <u>Cholelithiasis, Multiple gall stones</u> DUE TO <u>Non treated at 7-66</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20e. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July 26, 1966</u> to <u>3-18-67</u> that (I) (we) last saw the deceased alive on <u>3-18-1967</u> and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles E. Thompson</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3-18-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. CHARLES THOMPSON</u> 22d. ADDRESS <u>2903 W. WOODWELL ROAD, 21222, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3/21/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u> 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. F. SADOWSKI & SONS, 1808 EASTLAN AVE.</u> 25a. REC'D BY REGISTRAR <u>20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03255

1 PLACE OF DEATH a COUNTY <i>Balto.</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. but on Residence before admission) a STATE <i>Md.</i> b COUNTY <i>Balto.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c LENGTH OF STAY IN 1b <i>15 min</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Balto. Co. Gen. Hosp.</i>		d. STREET ADDRESS <i>7310 Droman Rd.</i>	
3 NAME OF DECEASED (Type or print) <i>CATHERINE MARIE KRAJEWSKI</i>		4 DATE OF DEATH <i>Mar 8 1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>Mar 28 '86</i>
10a USUA. OCC. PAT. ON (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Poland.</i>
13 FATHER'S NAME <i>unknown</i>		14 MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <i>Regina Krajewski</i>		Address <i>7319 Elmwood</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple injuries</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>E Fractured Skull</i> (c) <i>Due to</i>			INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <i>Backed over by car.</i>	
20c TIME OF INJURY Month, Day, Year <i>8:44 am Mar 8 1967</i>	20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Driveway of home - Balto 7</i>	20f. (City or town) (County) (State) <i>Balto Md</i>
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-11-1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cantius</i>		23d. LOCATION (City or Town) (County) (State) <i>Windber, Pennsylvania</i>	
24. FUNERAL DIRECTOR <i>Ellsworth Armacost</i> ADDRESS <i>Ellsworth Armacost - 4600 Liberty Hghts. Ave.</i>		25a. REC'D BY REGISTRAR <i>MAR 10 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

22. DATE SIGNED

3-8-1967

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03263

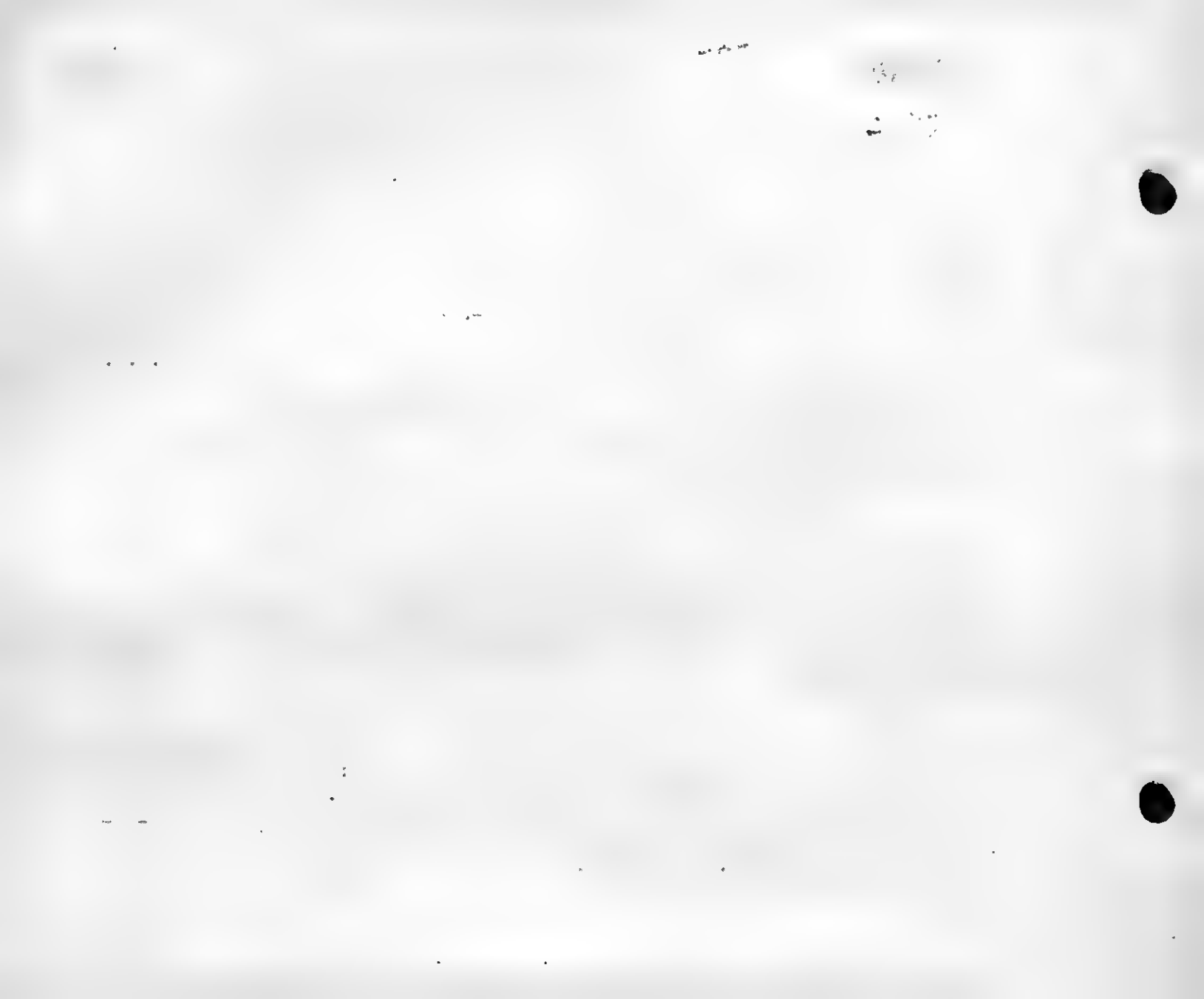
CERTIFICATE OF DEATH

03256

1 PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY in 1b 53yrs10mth15dys c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. City	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d STREET ADDRESS Bay View Hospital e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Kral		4 DATE OF DEATH Month Day Year March 29 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-23-88
9 AGE (In years last birthday) yrs 78		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical worker		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joseph Kral		14 MOTHER'S MAIDEN NAME Magdalene Snerha	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 219-54-3196-T	
17 INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1997 Bronchopneumonia; organism unknown DUE TO (b) Pulmonary metastases DUE TO (c) Fibrosarcoma of the abdomen			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from 5-14-13 , 19 9:35 to March 29 67 , that (x) (we) last saw the deceased alive on March 29 , 19 67 , and that death occurred at 9:35 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 3-29-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3/31/67	23c NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR <i>John Cole Baker Inc.</i>		25a REC'D BY REGISTRAR APR 4 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

03264

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03257

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital		d STREET ADDRESS 1538 Oakridge Road	
3 NAME OF DECEASED (Type or print) First STEPHANIE Middle Page Last KRAMER		4 DATE OF DEATH Month March Day 15 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 4, 1940
9 AGE (In years last birthday) yrs 26		10a IF UNDER 1 YEAR Months 1 Days 15 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME W. Frank Just		14 MOTHER'S MAIDEN NAME Ethel V. Smith	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 214-38-4768	
17 INFORMANT Mr. Charles P. Kramer		Address same address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 8164 IMMEDIATE CAUSE (a) Cranio-cerebral Injury. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver in auto-auto collision.	
20c TIME OF INJURY Month, Day, Year 12:05 3/ 11 1967	20d INJURY OCCURRED Where <input type="checkbox"/> at work Not White <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street	20f (City or town) (County) (State) Baltimore Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 3/16/67	
EXAMINER'S NAME (Type) Charles S. Petty		Address (Street, city, town, or county) Baltimore, Md.	
23a BURIAL, CREMATION REMOVAL, SPECIFY Burial	23b DATE THEREOF 3/18/1967	23c NAME OF CEMETERY OR CREMATORIUM Dulaney Valley Memorial	23d LOCATION (City or Town) (County) (State) Cockeysville, Md.
24 FUNERAL DIRECTOR Wm. J. Fisher & Sons		25a REC'D BY REGISTRAR Baltimore, Md.	25b REGISTRAR'S SIGNATURE Charles S. Petty

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

BP

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03265

CERTIFICATE OF DEATH

03258

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 127 DAYS		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTIMORE - 21213		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3438 ERDMAN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH P. KRASTEL		First Middle Last		4. DATE OF DEATH MARCH 17 19 67		Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/14/91		9 AGE (n years last birthday) yrs. 75	F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER ROLLER MAN			10b. KIND OF BUSINESS OR INDUSTRY PRINTING PRESS		11 BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME PHILIP KRASTEL				14. MOTHER'S MAIDEN NAME IDA GORSUCH GOSH			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO 218 18 36 25		17 INFORMANT CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GASTRIC PERFORATION, ACUTE DUE TO (b) CEREBRAL THROMBOSIS (c) LOBAR PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 13401							INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that this hospital attended the deceased from 11/10/66 , 19, to 3/17/67 , 19, that (s) (we) last saw the deceased alive on 3/17/67 , 19, and that death occurred at M, from causes and on the date stated above.							
22a. SIGNATURE George Dudas, M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED 3/17/67	
22c PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.				22d ADDRESS VAH FORT HOWARD, MARYLAND			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3/20/67		23c NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR SCHIMUNEK FUNERAL HOME		25b REGISTRAR'S SIGNATURE Charles J. J...	
				DATE MAR 22 1967			
3331 Brehms Lane, Baltimore, Md.							

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03266

CERTIFICATE OF DEATH

03259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21206	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 6517 Alta Ave.	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Ann KROCHESKI		4 DATE OF DEATH Month Day Year March 11, 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1933 September 1, 1933
9 AGE (In years last birthday) 33 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dominic Gallo		14. MOTHER'S MAIDEN NAME Antoinette Konopka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Bernard M. Krocheski		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Sub arachnoid hemorrhage 330X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/27/</u> 19 <u>67</u> , to <u>3/11/</u> 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>3/11/</u> 19 <u>67</u> , and that death occurred at <u>7:34AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <i>Pridipongse Vithespongse</i>		22b. DATE SIGNED March 11, 1967	
22c. PHYSICIAN'S NAME (Type) Pridipongse Vithespongse, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/14/67.	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Yager</i>	



03267

CERTIFICATE OF DEATH

03260

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d STREET ADDRESS 1509 LANCASTER STREET	
3 NAME OF DECEASED (Type or print) First JOSEPH Middle -- Last KULAK		4. DATE OF DEATH Month MARCH Day 13 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH SEPT. 3, 1896
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MARINE ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY SHIPPING	
11 BIRTHPLACE (County & State, or foreign country) SHAMOKIN, PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER KULAK		14. MOTHER'S MAIDEN NAME AMELIA MN: UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 212 18 55 50	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE AND CONGESTIVE DUE TO (c) HEART FAILURE			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PULMONARY EMPHYSEMA			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 3/5/67 , 19__, to 3/13/67 , 19__, that he (we) last saw the deceased alive on 3/13/67 , 19__, and that death occurred at 2:30 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR JOSEPH N. ZANNINO FUNERAL	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		DATE MAR 15 1967	
257 S. COMBING ST. BALTIMORE, MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonappers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03268

CERTIFICATE OF DEATH

03261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Towson, Md. 21204				d. STREET ADDRESS 9407 Fullerdale Ave. #21234		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLOTTE R. KYLE				4. DATE OF DEATH Month Day Year March 29 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-15		9. AGE (n years last birthday) yrs 51	IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Security Administration			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Sylvanus R Weaver				14. MOTHER'S MAIDEN NAME Lillian Schwemm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-01-1169		17. INFORMANT Family Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive intra Cerebral Hemorrhage DUE TO Perry Aneurysm of the left posterior cerebral artery (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3-28- , 19 67 to 3-29-67 , 19 67 , that (X) (we) lost saw the deceased alive on 3-29- 1967, and that death occurred at 4:00 p.m. from causes and on the date stated above.							
22a. SIGNATURE Sam J. Misanik				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-29-67	
22c. PHYSICIAN'S NAME (Type) Lawrence T. Misanik				22d. ADDRESS 7620 York Road, Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/1/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				25a. REC'D BY REGISTRAR MAK 31 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

July 1944



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03269

CERTIFICATE OF DEATH

03262

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		d. STREET ADDRESS Shore Acres	
3 NAME OF DECEASED (Type or print) ELIZABETH (BESSIE) LANG		4. DATE OF DEATH Month March , Day 16 , Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 83
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dwight Tuttle		14. MOTHER'S MAIDEN NAME Annie Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Address Mr. John D. Lang, 13 Summitt Avenue 21228	
16. SOCIAL SECURITY NO. 219-30-1614 B			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1966 , to 3-16-67 , 19__, that (I) (we) last saw the deceased alive on 3-16-67 19__, and that death occurred at 2:00 P. M. from causes and on the date stated above			
22a. SIGNATURE John Nesbitt		22b. DATE SIGNED 3-18-67	
22c. PHYSICIAN'S NAME (Type) Dr. John Nesbitt		22d. ADDRESS 1009 Frederick Ave., Balto., Md. 21228	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-20-1967	23c. NAME OF CEMETERY OR CREMATORY Swartz Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore City, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR DATE MAR 20 1967	
		25b. REGISTRAR'S SIGNATURE John H. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03270

CERTIFICATE OF DEATH

03263

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4001 Chesley Avenue		d. STREET ADDRESS 4001 Chesley Avenue 6	
3. NAME OF DECEASED (Type or print) George Frederick Lehmann		4. DATE OF DEATH Month 3 Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1888
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Lehmann		14. MOTHER'S MAIDEN NAME Marie Blauman-Zukow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-9058	
17. INFORMANT Mr Philip T. Thomas 6709 Collinsdale Road		Address 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease with congestive failure DUE TO (c) 34/3			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1, 1962 , to Mar 23, 1967 , that (I) (we) lost saw the deceased alive on Feb 1, 1967 , and that death occurred at 11 M, from causes and on the date stated above.			
22a. SIGNATURE Rudolph H. Spitzberg		22b. DATE SIGNED March 24, 1967	
22c. PHYSICIAN'S NAME (Type) Dr Rudolph H. Spitzberg		22d. ADDRESS 338 W. Pratt Street Baltimore Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-27-1967	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Balto. Co. Md.
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		25. REGD BY REGISTRAR 36 DATE 27 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~these~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03271			CERTIFICATE OF DEATH				03264		
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6912 Golden Ring Road					d. STREET ADDRESS 343 Worton Road #21			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Mary Lengsfeld					4. DATE OF DEATH Month March Day 13 Year 1967				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1906		9. AGE (in years last birthday) yrs. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Julius B. Richter					14. MOTHER'S MAIDEN NAME Mary Leikuhler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 212-01-5175		17. INFORMANT Daughter Address Lillian M. Duke, 6912 Golden Ring Rd. #21					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cocaine of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 66 to Mar 13 , 19 67 , that (I) (we) last saw the deceased alive on Mar 13 , 19 67 , and that death occurred at 11:45 P M, from causes and on the date stated above.									
22a. SIGNATURE Dr. Louis Seminoff				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3/15/67			
22c. PHYSICIAN'S NAME (Type) Dr. Louis Seminoff				22d. ADDRESS 2108 Orems Road (Aero Acres)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13				25a. REC'D BY REGISTRAR MAR 16 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

03272

CERTIFICATE OF DEATH

03265

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 819 S. HANOVER STREET	
3 NAME OF DECEASED (Type or print) First BUDDIE Middle - - - Last LESTER		4 DATE OF DEATH Month MARCH Day 26 Year 19 67	
5 SEX MALE	6. CO. OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 20, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years lost birthday) yrs 78
11. BIRTHPLACE (County & State, or foreign country) LAWRENCEVILLE, VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DERMIS LESTER		14. MOTHER'S MAIDEN NAME DINAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 212 01 90 62	
17. INFORMANT VA HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, ACUTE DUE TO (b) CEREBROVASCULAR ARTERIOSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 23 , 19 67 , to MARCH 26 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 26 , 19 67 , and that death occurred at 1254 M, from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b DATE THEREOF March 28, 1967	23c NAME OF CEMETERY OR CREMATORY JONES CEMETERY	23d LOCATION (City or Town) (County) (State) LAWRENCEVILLE, VIRGINIA
24. FUNERAL DIRECTOR ORIS P. JONES		25a REC'D BY REGISTRAR APR 3 1967	25b REGISTRAR'S SIGNATURE Charles Judge

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Item #9 Film #9381 4/5/67

03273 03266

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN b. Towson Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Presbyterian Home

2. USUAL RESIDENCE (Where deceased lived, if institution, give name before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Baltimore
d. STREET ADDRESS 916 W. 27th St. / Presbyterian Home • IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ida Middle L. Last Lilly
4. DATE OF DEATH Month March Day 27 Year 1967

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Oct. 31, 1878 9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Balto., Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Thomas Lilly 14. MOTHER'S MAIDEN NAME Sarah E. Phelps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 17. INFORMANT Address Presbyterian Home of Maryland Georgia Ct. & Dixie Drive

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho pneumonia
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASCVD

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ INTERVAL BETWEEN ONSET AND DEATH 48 hrs -yrs

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) Schepel attended the deceased from Jan. 1958 to March 27, 1967, that (I) (he) last saw the deceased alive on March 27, 1967, and that death occurred at 5 pm from the causes and on the date stated above.

22a. SIGNATURE Schepel M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 3-29-67

22c. PHYSICIAN'S NAME (Type) S.J. Venable, Jr. M.D. 22d. ADDRESS 7215 York Road, Baltimore, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/30/67 23c. NAME OF CEMETERY OR CREMATORY Franklinville Cem. 23d. LOCATION (City, town or county) (State) Bradshaw, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212 25a. REC'D BY REGISTRAR APR 3 1967 25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03274

03267

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Reisterstown</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Saffell Road</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Reisterstown</u> d. STREET ADDRESS <u>Saffell Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>THOMAS</u> Last <u>LITTLE</u>			4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>June 26, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Polk Singleton</u>					
14. MOTHER'S MAIDEN NAME <u>Harriet Norris</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u> </u>					
16. SOCIAL SECURITY NO. <u>220-54-7105</u>		17. INFORMANT (Daytime) <u>838-5028</u> Address <u>Mrs. Maud I. Amos, RFD # 3, Box # 28, Bel Air, Maryland 21014</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis - decompensated</u> DUE TO <u>Emphysema -</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic obstructive pulmonary disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>1 year</u> <u>years</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1967</u> to <u>3-17-1967</u> , that (I) (we) last saw the deceased alive on <u>3-17-1967</u> , and that death occurred at <u>7:30</u> M. from the causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>3-17-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Saffell MD</u>				22d. ADDRESS <u>Reisterstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>			
23d. LOCATION (City, town or county) <u>Bel Air Harf. Co. Md.</u>		23e. (State) <u>21014</u>					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams</u>				25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. DATE <u> </u>			

MEDICAL CERTIFICATION

03275

CERTIFICATE OF DEATH

03268

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY ---		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Randallstown		c. LENGTH OF STAY IN 1b Baltimore 21211			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home			d. STREET ADDRESS 3801 Roland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lloyd B. Loats			4. DATE OF DEATH Month March Day 13 Year 1967		
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1892	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months --- Days --- Hours --- Min ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Business		11. BIRTHPLACE (County & State, or foreign country) Manchester, Md.	
13. FATHER'S NAME Horatio Loats			14. MOTHER'S MAIDEN NAME Mary Baltozer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 216-01-89214		17. INFORMANT Address 21207 Mrs. Evelyn Provenzano-7105 Manila Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 232X IMMEDIATE CAUSE (a) Cerebral Thrombosis, old & recent DUE TO Atherosclerosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- (c) ---					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Sept 5, 1965 to March 13, 1967 , that (I) (we) last saw the deceased alive on March 2, 1967 , and that death occurred at --- M, from causes and on the date stated above					
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-14-67	
22c. PHYSICIAN'S NAME (Type) Dr. Rafael Perez-Mera		22d. ADDRESS 7306 Liberty Rd. Balt., Md. 21207			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville 8 Md.	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		25a. REGISTRY BY REGISTRAR MAR 16 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03276

03269

1. PLACE OF DEATH a. COUNTY Baltimore Co.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shirley Ave.				d. STREET ADDRESS Rolland Ave.			
3. NAME OF DECEASED (Type or print) First Edna Middle Ray Last Lowe				4. DATE OF DEATH Month March Day 18 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1886	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		11. BIRTHPLACE (County & State, or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Office Work			
13. FATHER'S NAME Thomas Lowe				14. MOTHER'S MAIDEN NAME Alice Hann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) NO				16. SOCIAL SECURITY NO. 212-07-2587-A		17. INFORMANT Mrs. Tilly Bates Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO (b) Hepatic metastasis DUE TO (c) Descending colon carcinoma						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 1966 , to March 1967 , that (I) (we) last saw the deceased alive on 3/18 19 67 , and that death occurred at 1:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Philip Bernstein				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/18/67	
22c. PHYSICIAN'S NAME (Type) PHILIP BERNSTEIN				22d. ADDRESS 112 CHARLEY DR REISTERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City, town or county) (State) Greenmount, Md.	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home Hampstead, Md.				25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03277

CERTIFICATE OF DEATH

03270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b Halethorpe	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1203 Oakland Terrace Road		d. STREET ADDRESS 1203 Oakland Terrace Road	
3. NAME OF DECEASED (Type or print) BERTHA A. Ludwig		4. DATE OF DEATH Month March Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-1880
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Tuebner		14. MOTHER'S MAIDEN NAME Mary C.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Roberta F. Braecklein, 1203 Oakland Rd.		Address Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro-vascular accident 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) Hypertensive cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 years 5 years 13 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 58 to Mar-12 , 1967, that (I) (we) last saw the deceased alive on Mar. 9 , 1967, and that death occurred at 2 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Dr. Louis E. Wice		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. Louis E. Wice		22d. ADDRESS 920 St. Paul Street Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-16-1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25. REC'D BY REG STRAR MAR 17 1967	
25a. REC'D BY REG STRAR DATE		25b. REG STRAR'S SIGNATURE Charles Judge	

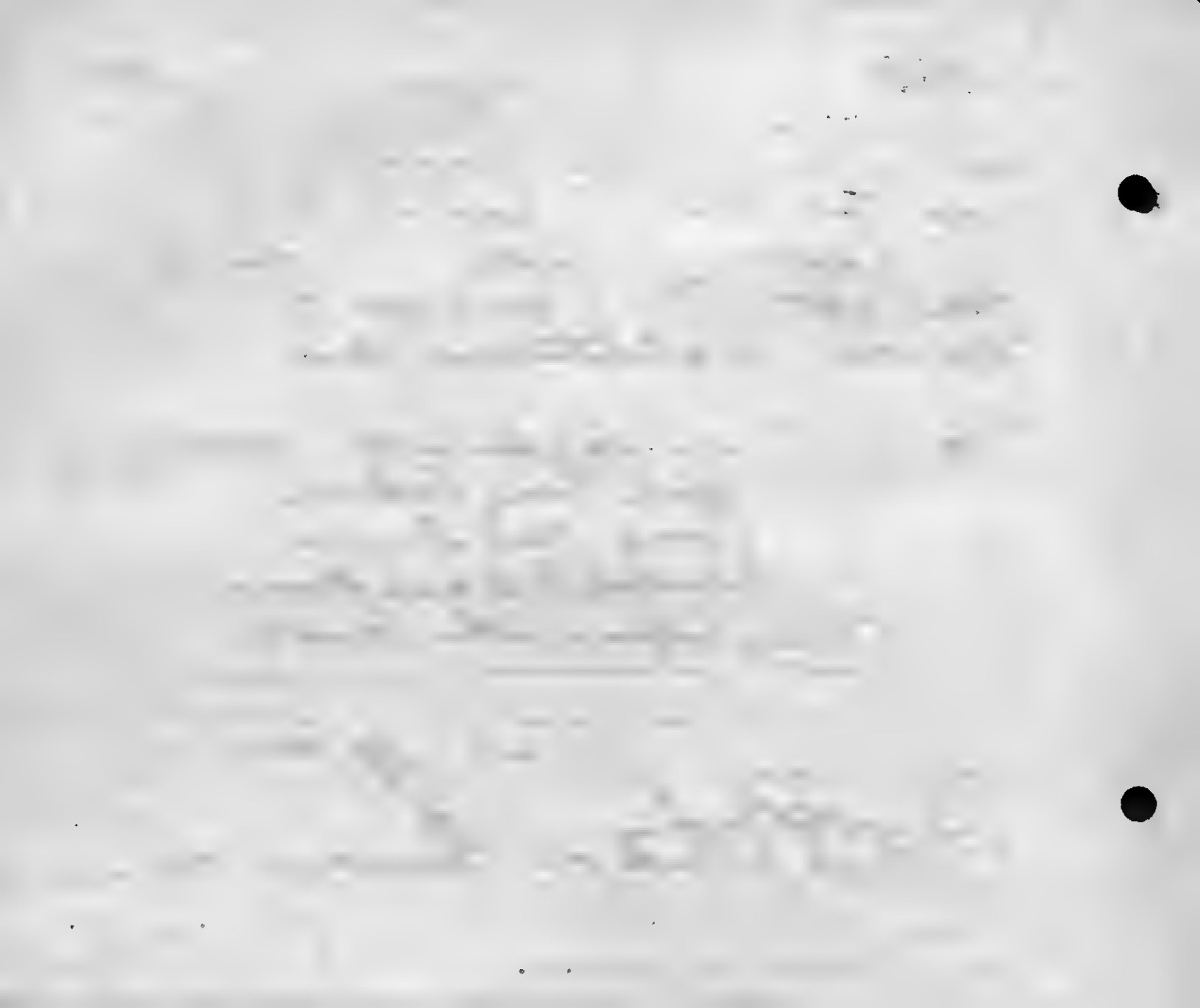
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL retained by the hospital or attending physician. TO FUNERAL TO BE FILED: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03278		03271	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		d. STREET ADDRESS <u>Upper Falls Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Upper Falls Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 2, 1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Denver Colorado</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>173-01-9376</u>	
17. INFORMANT <u>Lillian Lund</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Perforating Esophagus - Atherosclerotic</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Perforating Esophagus - Atherosclerotic</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4, 1967</u> to <u>March 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 27, 1967</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E Bush MD</u>		22b. DATE SIGNED <u>3/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 29, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grave Run Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hampstead, R.D. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 30 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ANNAPOLIS
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03279

CERTIFICATE OF DEATH

04446

Items #11 & 12 filled in

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Conv. Home 301 West Chesapeake Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 501 West University Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rufus Middle Charles Last Mac Lellan		4. DATE OF DEATH Month March Day 9 Year 1967	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ad Manager 10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR		9. AGE (In years last birthday) 86 yrs. 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur R. MacLellan		14. MOTHER'S MAIDEN NAME Louisa J. Talbot Address _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) None		16. SOCIAL SECURITY NO. _____ 17. INFORMANT Mr. Arthur MacLellan same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last, (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (the hospital) attended the deceased from 4/10 1967 to 3/9 1967 , that (I) (we) last saw the deceased alive on 3/9 1967 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Laurence C. Post M.D.		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST		22d. ADDRESS 6805 York Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/1967	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn, Maryland Woodlawn Cemetery		23d. LOCATION (City, town or county) Baltimore 21212 (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner & Sons		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE _____	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03280

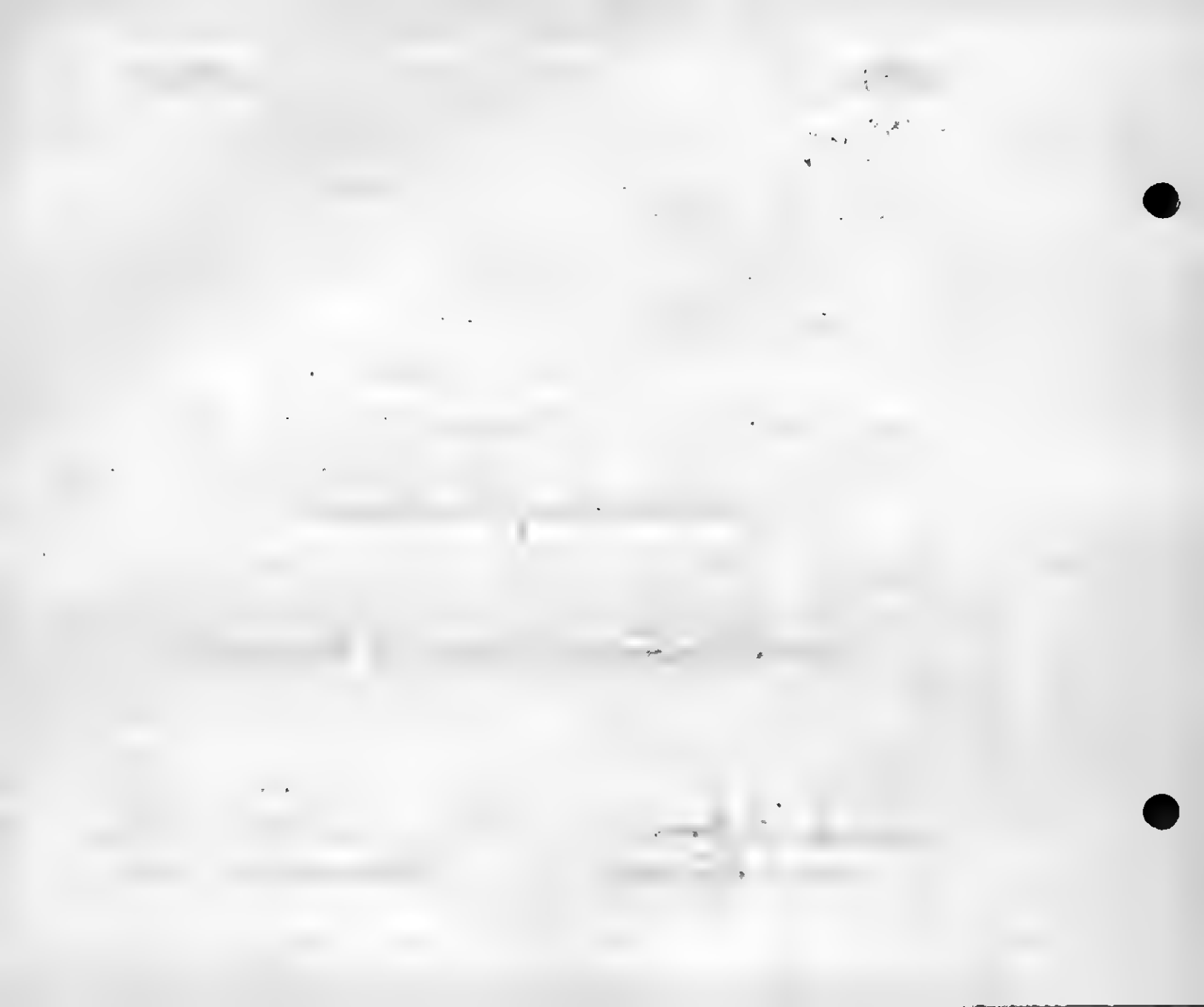
CERTIFICATE OF DEATH

03272

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keedysville	
c. LENGTH OF STAY IN 1b 10 years		d. STREET ADDRESS -	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Anna Middle MALATT Last MALATT		4. DATE OF DEATH Month 3 Day 13 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-13-10
9 AGE (In years last birthday) 56 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent	11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Malatt (Dec.)	
14 MOTHER'S MAIDEN NAME Effie Katherine Kelly (Dec.)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO none		17 INFORMANT Rosewood Records, Owings Mills, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Necrotizing Bronchopneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Institutionalization due to residual of Poliomyelitis			INTERVAL BETWEEN ONSET AND DEATH 5 days
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (a) (this hospital) attended the deceased from 12-26 , 19 56 , to 3-13 , 19 67 , that (b) (we) last saw the deceased alive on 3-13 , 19 67 , and that death occurred at 2:00 P.M. on 3-13 , 19 67 , and that death was caused by and on the date stated above.	
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 14 Mar 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/14/67	
23c. NAME OF CEMETERY OR CREMATORY Rosewood		23d. LOCATION (City or Town) (County) (State) Owings Mills Md	
24 FUNERAL DIRECTOR J F Eline + Sons Tristerstown Md		25a. REC'D BY REGISTRAR MAR 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03281

CERTIFICATE OF DEATH

03273

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 1 DAY		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 345 S. FURROW STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSE Middle C Last MARTIN		4. DATE OF DEATH Month MARCH Day 1 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUGUST 30, 1886
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN	
11. BIRTHPLACE (County & State, or foreign country) MINERAL COUNTY, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN B. MARTIN		14. MOTHER'S MAIDEN NAME MARTHA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO 220 07 65 92	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LAENNEC'S CIRRHOSIS DUE TO (c) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MARCH 1, 19 67 to MARCH 1, 19 67 , that (I) (we) saw the deceased alive on MARCH 1, 19 67 , and that death occurred at 1120P AM, from causes and on the date stated above			
22a. SIGNATURE <i>Peter V. Jovan</i>		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JOVAN, M. D.		22d. ADDRESS VAH FT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/6/67	23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i>		25a. REC'D BY REGISTRAR MAR 8 1967 DATE 25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>	
257 S. CONKLING ST. BALTIMORE, MD.			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03282

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b Hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital						a. STREET ADDRESS 601 Cranbrook Road			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Ralph Mason						4. DATE OF DEATH Month Day Year March 11 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1904		9. AGE (in years last birthday) 62 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Traffic Manager				10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Edward Mason						14. MOTHER'S MAIDEN NAME Mary Rau			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO 705-10-5081		17. INFORMANT Mrs. Jennie S. Mason 601 Cranbrook Rd 21030			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Cardiac, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Coronary Occlusion Sudden			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL CREMATION REMOVAL (Specify) Cremation			23b. DATE THEREOF 3/14/67		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Road 21204						25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03283					03275				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3yr3mth26dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1802 Morrell Park Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Victoria Middle Frances Last Matalis			4. DATE OF DEATH Month March Day 13 Year 19 67						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1888		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress				10b. KIND OF BUSINESS OR INDUSTRY Aluminum Co		11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Vabalas					14. MOTHER'S MAIDEN NAME Leah Vabalas				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-01-5393		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 440X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Bilateral pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain dis.									INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (if this hospital) attended the deceased from Nov. 17 19 63 to March 13 19 67 , that (we) last saw the deceased alive on March 13 19 67 , and that death occurred at 6:25 M, from the causes and on the date stated above.									
22a. SIGNATURE Evelio A. Felipe, M.D.			22b. DATE SIGNED 3-14-67		22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.				
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		23d. LOCATION (City, town, or county) (State) 4430 Delmar Rd. 12.		
24. FUNERAL DIRECTOR John J. ...			25a. REC'D BY REGISTRAR 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge				

237nd



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03276

1 PLACE OF DEATH a. COUNTY Balto.		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. General Hospital		d. STREET ADDRESS 5414 Gwynndale Ave.	
3 NAME OF DECEASED (Type or print) First Arthur Middle B. Last Maton		4 DATE OF DEATH Month Mar. Day 14 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 1, 1890
9. AGE (n years last birthday) yrs 76		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Balto. City Water Dept.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John G. Maton		14. MOTHER'S MAIDEN NAME Elizabeth Dorsey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-12-0593	
17. INFORMANT Mrs. Glenda Maton, 5414 Gwynndale Ave.,		Address Balto. 7, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease 4201 DUE TO Candians, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 3-14-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BIRTHAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/67	
23c. NAME OF CEMETERY OR CREMATORY Western		23d. LOCATION (City or town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR John T. Stansbury		25a. REC'D BY REGISTRAR MAR 16 1967	
25b. FUNERAL HOME 6411 Windsor Mill Rd.		25c. ADDRESS	



CERTIFICATE OF DEATH

03285

03277

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 53yr10mth12dys Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Bay View Hospital	
3. NAME OF DECEASED (Type or print) Samuel First Middle Last		4. DATE OF DEATH March 26 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878
9. AGE (In years) 88 yrs.		10. F UNDER 1 YEAR Months Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		12. C. TIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel L. Maxwell		14. MOTHER'S MAIDEN NAME Emma ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219-54-3228 J1	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic cardiovascular Heart Dis DUE TO (c) Arteriosclerosis, generalized, senile				INTERVAL BETWEEN ONSET AND DEATH acute 20yr. 25yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from May 14, 1913 to March 26, 1967 , that (2) (we) last saw the deceased alive on March 26, 1967 , and that death occurred at 8:00 p.m. , from causes and on the date stated above.				
22a. SIGNATURE Anthony J. Young, M.D.		22b. DATE SIGNED 26-27-67		
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. BURIAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.		25a. REC'D BY REGISTRAR MAR 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03286

CERTIFICATE OF DEATH

03278

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>60 years</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Middle River</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>99 Glenwood Road</u>	
3. NAME OF DECEASED (Type or print) <u>Percy B. McAlpin</u> First Middle (McAlpin) Last		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 28, 1896</u>
10a. USBA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Worker</u>	9. AGE (In years last birthday) <u>71</u> yrs IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (County & State, or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>McAlpin</u>		14. MOTHER'S MAIDEN NAME <u>McAlpin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>233-32-6347</u>	
17. INFORMANT <u>Mrs Cassie McAlpin</u> Address <u>99 Glenwood Road</u>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 3</u> , 19 <u>67</u> , and that death occurred at <u>A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R J Lyden</u>		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Lyden, M.D.</u>		22d. ADDRESS <u>6402 Golden Ring Road</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>
24. FUNERAL DIRECTOR <u>Leo & Cook</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>7208 Hanford Road</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03287

CERTIFICATE OF DEATH

03279

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Md b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium, Md.		c. LENGTH OF STAY IN 1b 5 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2516 Lawnside Rd, Timonium, Md. 21093		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2516 Lawnside Rd.	
d. STREET ADDRESS 2516 Lawnside Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Thomas J. McMahon		4 DATE OF DEATH Month 3 , Day 26 , Year 1967	
5 SEX M	6 COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 5, 1919
9 AGE (In years lost birthday) yrs. 47		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng. Western Electric	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) New York, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Thomas J. McMahon	
14. MOTHER'S MAIDEN NAME Mary Delaney		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes. WWII	
16 SOCIAL SECURITY NO 131 07 0243		17 INFORMANT Catherine M. McMahon, Timonium, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Myocardial Infarction DUE TO (c) ASCD		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/1/66 , 19 to 3/26 , 1967, that (I) (we) last saw the deceased alive on 3/26 , 1967, and that death occurred at 1:35 P.M. from causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) ROBERT J. MAHON		22d ADDRESS 204 E JOPPA RD TOWSON MD	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/67	
23c NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03288

03280

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastwood</u> c. LENGTH OF STAY IN 1b <u>7228 Stratton Way # 21224</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7228 Stratton Way # 21224</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastwood</u> d. STREET ADDRESS <u>7228 Stratton Way #21224</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GILBERT</u> <u>SAMUEL</u> <u>MICHAEL</u> 4. DATE OF DEATH <u>March 16, 19 67.</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 5, 1903</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coil Stecker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steell Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wilbur G. Michael</u> 14. MOTHER'S MAIDEN NAME <u>Frances Varina</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>218-05-6090</u> 17. INFORMANT <u>Victoria E. Michael</u> Address <u>Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE HEART DISEASE</u> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> <u>15 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/59</u> , 19 <u>59</u> , to <u>3/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2/67</u> , 19 <u>67</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above 22a. SIGNATURE <u>Max Baer</u> M.D. 22b. DATE SIGNED <u>3/17/67</u> 22c. PHYSICIAN'S NAME (Type) <u>Max Baer</u> 22d. ADDRESS <u>7422 Eastern Blvd., Balto., 21224, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-20-67.</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> 23d. LOCATION (City, town or county) <u>Balto.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Zailer</u> ADDRESS <u>6224 Eastern Ave. Balto., Md.</u> 25a. REC'D BY REGISTRAR <u>APR 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03289

CERTIFICATE OF DEATH

03281

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 51 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 4700 Haldane Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) KENNETH A. MITCHELL		First Middle Last		4. DATE OF DEATH MARCH 6 19 67		Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/94		9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER		10b. KIND OF BUSINESS OR INDUSTRY WOOD		11. BIRTHPLACE (County & State, or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. MITCHELL				14. MOTHER'S MAIDEN NAME LAURA (KOONARD) Coonrod			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I		16. SOCIAL SECURITY NO. 214 03 72 12		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTENSIVE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) PULMONARY EDEMA DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH OLD & RECENT RECENT
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 1/14/67 , 19__, to 3/6/67 , 19__, that (X) (we) lost saw the deceased alive on 3/6/67 , 19__, and that death occurred at 7:00PM , from causes and on the date stated above							
22a. SIGNATURE HOWARD C. KRAMER, M. D.				22b. DATE SIGNED 3/7/67		22c. PHYSICIAN'S NAME (Type)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3-9-67		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL CEMETERY BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR RUCK FUNERAL HOME				25a. REG'D BY REGISTRAR DATE 9 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03290					03282						
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY 4. Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasaden d. STREET ADDRESS 43 Stone Drive e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Mrs. Mary Ellen Mitchell		4. DATE OF DEATH Month March Day 22 Year 1967		5. SEX F.		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/3/97	
9. AGE (In years last birthday) 70 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Chalk	
14. MOTHER'S MAIDEN NAME Mollie Eick		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-03-6314		17. INFORMANT Records, Mount Wilson State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive pulmonary emphysema DUE TO (b) CHL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from March 4, 1967 to March 22, 1967 , that (I) (we) last saw the deceased alive on March 22, 1967 , and that death occurred at 3:4 M. from the causes and on the date stated above.		22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Cem		23d. LOCATION (City, town or county) (State) Baltimore Md		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge		24. FUNERAL DIRECTOR McCully F H		ADDRESS 237 Patapsco Ave 21225		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

03291

CERTIFICATE OF DEATH

03283

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3</u> <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROSEWOOD STATE HOSPITAL</u>		d. STREET ADDRESS <u>1630 MILLER ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>TERRY</u> Middle <u>MONROE</u> Last <u>---</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>10</u> yrs IF UNDER 1 YEAR: Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min <u>---</u>
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAWRENCE TERRY MONROE</u>		14. MOTHER'S MAIDEN NAME <u>LORETTA LOUISE PINKNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> 471A DUE TO (b) <u>---</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>---</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (1) (we) last saw the deceased alive on <u>3/18/67</u> , 19 <u>67</u> , and that death occurred at <u>4:50</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT ALBURN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD.</u>
24. FUNERAL DIRECTOR <u>JOSEPH KNIGHT-F. HOME 1639 N. BROADWAY</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03292						03284					
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb — ? — d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. JOSEPH'S HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON 4, MARYLAND d. STREET ADDRESS 608 STEVENSON LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JANET E. T. MONTGOMERY			4. DATE OF DEATH Month 3 Day 3 Year 1967			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 15, 1894			9. AGE (In years last birthday) 72 yrs.			10. FUNERAL 1 YEAR <input type="checkbox"/> FUNERAL 24 HRS. <input type="checkbox"/>		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE			11b. KIND OF BUSINESS OR INDUSTRY HOUSE			12. BIRTHPLACE (County & State, or foreign country) SCOTLAND			13. CITIZEN OF WHAT COUNTRY? BRITAIN		
14. FATHER'S NAME JAMES C MONTGOMERY						15. MOTHER'S MAIDEN NAME VIOLET McINTYRE					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						17. SOCIAL SECURITY NO. 217-B-6228					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) Hypertensive Arteriosclerotic C.V. Disease c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. INTERVAL BETWEEN ONSET AND DEATH 2 hours years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb 1964 to 3 March, 1967 , that (I) (we) last saw the deceased alive on 3 March 1967 , and that death occurred 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Dr. L. Brown						22b. DATE SIGNED 3 March 67					
22c. PHYSICIAN'S NAME (Type) Dr. L. Brown						22d. ADDRESS 431 East Lake Ave 21212					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE THEREOF Mar-6-67			23c. NAME OF CEMETERY OR CREMATORY Green Mount			23d. LOCATION (City, town or county) (State) Baltimore-21202		
24. FUNERAL DIRECTOR Stewart Mowen						25a. REC'D BY REGISTRAR North-Av-21201					
25b. REGISTRAR'S SIGNATURE Charles Judge						DATE MAR 6 1967					



مجلس



الحمد لله رب العالمين
والصلاة والسلام على سيدنا محمد وآله
والمؤمنين

CERTIFICATE OF DEATH

03285

03293

1. NAME OF DECEASED
(Type or Print)

940 Thompson Blvd.
LEONARD R. ROZ, JR.

2. DATE AND HOUR OF DEATH

6:30 AM 3/7/67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

Name of deceased: LEONARD R. ROZ, JR.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

COUNTY: BALTIMORE

Baltimore - 21
940 Thompson Blvd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore, Md

D. STREET ADDRESS (If rural, give location)

940 Thompson Blvd

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

Aug 26, 1965

9. AGE (in years last birthday)

1

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Leonard R. Rozoy SR

14. MOTHER'S MAIDEN NAME

Marina Eckert

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Father

ADDRESS

ABOVE

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

Failure to Thrive

(B) DUE TO

Possible Metabolic

(C)

Disorder.

INTERVAL BETWEEN ONSET AND DEATH

21D. TIME OF INJURY (APPROX.)

While At Work

Not While At Work

22. I certify that (I) (this hospital) attended the deceased from February 15, 1967 to February 23, 1967 that (I) (we) last saw the deceased alive on February 17, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. Baghdassarian

M.D.

Attending Phys.

Med. Director

Staff Phys.

23B. DATE SIGNED

3/7/67

23C. PHYSICIAN'S NAME (Type)

H. BAGHDASSARIAN

M.D.

23D. ADDRESS

Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

3/9/67

24C. NAME OF CEMETERY or CREMATORY

HOLLY HILL

24D. LOCATION

BALTO MD.

VR A15 (4)
25M 1/67

25A. DATE RECEIVED BY HEALTH DEPT.

MAR 14 1967

25B. NAME OF REGISTRAR

John Charles Judge

25C. FUNERAL DIRECTOR

J. E. CONNELLY 300 MACE

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health prior to burial cremation or removal and to any event within 72 hours after death.

Released by Dr. Spitz - M.E. Office

03294

CERTIFICATE OF DEATH

03286

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 4740 Shramrock Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Mary Morris		4. DATE OF DEATH Month Day Year March 29, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-20
9. AGE (In years last birthday) yrs 47		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard E. Loewer		14. MOTHER'S MAIDEN NAME Katherine Walters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Morris, husband, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, metastatic of lung and brain secondary to carcinoma of breast. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from March 12, 19 67 , to March 29, 19 67 , that (we) last saw the deceased alive on March 29, 19 67 , and that death occurred at 6:00AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Jaime Ambrad</i>		22b. DATE SIGNED March 29, 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Ambrad, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/31/67	23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		25a. REC'D BY REGISTRAR MAR 30 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03295

CERTIFICATE OF DEATH

03287

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS Box 38		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle Joan East MOZINGO				4. DATE OF DEATH Month March Day 3 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-16-64	9. AGE (In years last birthday) 2 yrs.	10. IF UNDER 1 YEAR Months 2 Days 1	11. IF UNDER 24 HRS Hours 12 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ronald Edward Mazingo				14. MOTHER'S MAIDEN NAME Delores Joan Tucker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Address Rosewood Records, Owings Mills, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Respiratory difficulty DUE TO 12 hrs (c) Prob. aspiration pneumonia DUE TO 12 hrs							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Microcephalic blind deaf severe mental retardation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 6-9 , 19 66 , to 3-3 , 19 67 , that (I) (X) saw the deceased alive on 3-3 , 19 67 , and that death occurred at 9:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE Barbara W. Mazon				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-3-67	
22c. PHYSICIAN'S NAME (Type) Rosewood State Hospital				22d. ADDRESS Rosewood State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 5, 1967		23c. NAME OF CEMETERY OR CREMATORY Southern Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.	
24. FUNERAL DIRECTOR W. H. Hitchens Funeral Home				ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR Charles Judge	
				DATE MAR 7 1967		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

03296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03288

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY Harford	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c LENGTH OF STAY IN 1b Forest Hills	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Howard Hospital		d. STREET ADDRESS 1400 Bowles Terrace	
3 NAME OF DECEASED (Type or print) First PAUL Middle A. Last MULLIN		4. DATE OF DEATH Month March Day 19 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1934
9 AGE (In years last birthday) 32 yrs		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sr. Engineer		10b KIND OF BUSINESS OR INDUSTRY Martin Co.	
11 BIRTHPLACE (State or foreign country) East Lansdowne, Pa.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph P. Mullin		14. MOTHER'S MAIDEN NAME Evalyn Craft	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO 209-26-0342	
17. INFORMANT Mrs. Anne E. Mullin		Address (Same)	
18 CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral contusions and subdural hemorrhage DUE TO (c) Cerebral contusions and subdural hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) Driver in auto-truck collision			
20c TIME OF INJURY Month, Day, Year Hour a.m. 12:03 1 20 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f (City or town) (County) (State) Baltimore Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		22. DATE SIGNED 3/20/67	
EXAMINER'S NAME (Type) Charles S. Petty		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/22/1967	
23c NAME OF CEMETERY OR CREMATORY Baltimore, National		23d LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a REC'D BY REGISTRAR DATE MAR 21 1967	
25b REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH-DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03297

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03289

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived f. institution Residence before admission) a STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d STREET ADDRESS 412 Hillen Rd.	
3 NAME OF DECEASED (Type or print) First FRANK Middle RICHARD Last MURPHY		4. DATE OF DEATH Month 3 Day 10 Year 19 67	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/4/91
9 AGE (In years last birthday) 75 yrs		10 IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b KIND OF BUSINESS OR INDUSTRY Railroad	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Phillip A. Murphy		14 MOTHER'S MAIDEN NAME Carrie P. Fish	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 213-12-6307A	
17 INFORMANT Donald R. Murphy-412 Hillen Rd.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 442X IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Arteriosclerotic Cardio Renal DUE TO Vascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH Sudden 5+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D. EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Entombment		23b DATE THEREOF 3/13/67	
23c NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.		25 REC'D BY REGISTRAR MAR 14 1967	
26 REGISTRAR'S SIGNATURE Charles Judge		27 DATE SIGNED 3/11/67	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03298

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03290

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN ID 2 mos. 23 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH NMN NAVIASKY				4. DATE OF DEATH Month Day Year 3 9 1967			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-15-1900	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OWNER				10b. KIND OF BUSINESS OR INDUSTRY Retail		11. BIRTHPLACE (County & State, or foreign country) BALTO, MD.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME NATHAN NAVIASKY				14. MOTHER'S MAIDEN NAME HILLMAN, Jennie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN				16. SOCIAL SECURITY NO. 219-12-8874		17. INFORMATION Not Report	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF LUNG DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-15-1967 , to 3-9-1967 , that (I) (we) last saw the deceased alive on 3-9-1967 , and that death occurred at 6:52 AM , from the causes and on the date stated above.							
22a. SIGNATURE Rann K. Chmiller				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS GREATER BALTO. MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/10/67		23c. NAME OF CEMETERY OR CREMATORY Beth Elshoh Cng		23d. LOCATION (City, town or county) (State) Balto, Md	
24. FUNERAL DIRECTOR Sol Lerman - Person				25a. REC'D BY REGISTRAR 13		25b. REGISTRAR'S SIGNATURE Charles Judge	

100 1/4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03299 </div> <div> CERTIFICATE OF DEATH </div> <div> 03291 </div> </div>																				
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 28yr5mth14dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1110 Washington Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Mary Middle Josephine Last Noone			4. DATE OF DEATH Month March Day 31 Year 19 67			5. SEX female			6. COLOR OR RACE white			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 14, 1893			9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework						10b. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTH PLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.								
13. FATHER'S NAME John Noone						14. MOTHER'S MAIDEN NAME Sarah Callahan														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-54-3258T			17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, moderate, with psychotic reaction												INTERVAL BETWEEN ONSET AND DEATH								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 17, 1938 , to March 31, 1967 , that (I) we last saw the deceased alive on March 31, 1967 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.																				
22a. SIGNATURE <i>Evelio A. Felipe</i>						22b. DATE SIGNED 3-31-67			22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL, Baltimore, Maryland 21228								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/5/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral			23d. LOCATION (City, town or county) (State) Balto Md												
24. FUNERAL DIRECTOR John J. Cowan						25a. REC'D BY REGISTRAR APR 4 1967			25b. REGISTRAR'S SIGNATURE <i>Charles J. [illegible]</i>											

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03300

CERTIFICATE OF DEATH

03292

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bent Nursing Home</u>		d. STREET ADDRESS <u>1014 Wheaton Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES MORRIS</u>		4. DATE OF DEATH <u>March 30</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 30 1933</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>34</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Morris</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT <u>Philip Bernstein</u> Address <u>#2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X DUE TO (b) <u>HYPERTENSIVE HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>HYPERTENSION</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 27</u> , 19 <u>67</u> , to <u>March 30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 27</u> , 19 <u>67</u> , and that death occurred at <u>7:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Philip Bernstein</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip Bernstein</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton Montgomery Md</u>
24. FUNERAL DIRECTOR <u>Robert L. ...</u>		25. DEED BY REGISTRAR <u>APR 5 1967</u>	
26. REGISTRAR'S SIGNATURE <u>John ...</u>		27. REGISTRAR'S SIGNATURE	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03301

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03293

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if inst. on Res. before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 21227		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 5707 First Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5707 First Avenue -				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last RICHARD JOHN NORRIS				4 DATE OF DEATH Month Day Year 3 14 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-8-1946	9 AGE (In years last birthday) 20 yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME James A. Norris				14 MOTHER'S MAIDEN NAME Florence D. Gillingham			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 218-42-6678		17 INFORMANT Address Mr. James A. Norris, 5707 First Ave. 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 3-15-67	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3-18-1967		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229				25a REC'D BY REGISTRAR MAR 21 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03302

CERTIFICATE OF DEATH

03294

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1811 Roland Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE West Virginia b. COUNTY Bridgeport c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stout Street d. STREET ADDRESS Stout Street	
3. NAME OF DECEASED (Type or print) First Maude Middle M. Last Nuzum		4. DATE OF DEATH Month March Day 15 Year 1967	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. AGE (In years, last birthday) 93 yrs. IF UNDER 1 YEAR: Months 93 Days 93 Hours 93 Min. 93		9. AGE (In years, last birthday) 93 yrs. IF UNDER 1 YEAR: Months 93 Days 93 Hours 93 Min. 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY West Virginia 11. BIRTHPLACE (Country & or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? Mary		13. FATHER'S NAME Harlow Wilkinson 14. MOTHER'S MAIDEN NAME Mrs. George Bowles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. 1811 Roland Ave. Ruxton, Maryland 17. INFORMANT Mrs. George Bowles		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4500 DUE TO myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 hours 3 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Feb 15, 1967, to March 15, 1967, the (I) (we) last saw the deceased alive on March 15, 1967, and that death occurred at 9 P.M. from the causes and on the date stated above. 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1967 to March 15, 1967 , that (I) (we) last saw the deceased alive on March 15, 1967 , and that death occurred at 9 P.M. from the causes and on the date stated above. 22a. SIGNATURE George T. Gilmore 22b. DATE SIGNED March 15, 1967 22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE 22d. ADDRESS YORK RD LUTHERVILLE, MD		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 3/16/1967 23c. NAME OF CEMETERY OR CREMATORY Bendeum Cemetery 23d. LOCATION (City, town or county) (State) Bridgeport, W. Va. 25a. REC'D BY REGISTRAR MAR 17 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03303

CERTIFICATE OF DEATH

03295

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b 21234	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. STREET ADDRESS 3042 Woodside Avenue	
3 NAME OF DECEASED (Type or print) First Margaret Middle E. Last O'Connell		4 DATE OF DEATH Month March Day 24 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 15, 1895
9 AGE (in years lost birthday) yrs 71		10 UNDER 1 YEAR Months 1 Days 10 Hours 10 Min 10	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Hospital	
11 BIRTHPLACE (County & State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William J. O'Connell		14 MOTHER'S MAIDEN NAME Margaret Thornton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-20-2047	
17. INFORMANT Mrs. Irene Juda		Address 3042 Woodside Avenue-21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Post-operative Hiatal Hernia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 12, 1967 to March 24, 1967 , that (I) (we) last saw the deceased alive on March 24, 1967 and that death occurred at 4:00 P.M. from causes and on the date stated above.			
22a SIGNATURE Antonio Razo		22b. DATE SIGNED March 24, 1967	
22c PHYSICIAN'S NAME (Type) Antonio Razo		22d ADDRESS 7620 York Road, Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL burial	23b DATE THEREOF 3-27-67	23c. NAME OF CEMETERY OR CREMATORY Saint Peter's Cemetery	23d LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR John C. Miller Inc-415 Delair Road-21206		25a. REC'D BY REGISTRAR MAR 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

03304

CERTIFICATE OF DEATH

03296

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto.		c. LENGTH OF STAY IN 1b 43 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Balto. 15	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6514 Mt. Vernon Ave.		d. STREET ADDRESS 6514 Mt. Vernon Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Florence V. Oler			4. DATE OF DEATH Month March Day 4 Year 19 67		
5 SEX F	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/28/1896	9. AGE (n years last birthday) yrs. 70	IF UNDER 1 YEAR Months 4 Days 1 Hours 15 Min.
10a. OCC. PAT ON (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Md.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Sprinkle			
14. MOTHER'S MAIDEN NAME Grace Ward		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO		17. INFORMANT Address 21215 Virginia M. Dillon 6514 Mt. Vernon Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cordeio-vascular Disease DUE TO (c) Complication of being with melanoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					INTERVAL BETWEEN ONSET AND DEATH 4 hours 18 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chalcopytosis with cholelithiasis + Calc of Liver					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1966 , to 3/4 1967 , that (I) (we) last saw the deceased alive on 3/4 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above					
22a. SIGNATURE Grace E. Jones, M.D.		22b. DATE SIGNED 3/7/67		22c. PHYSICIAN'S NAME (Type) Dr. Grace Jones	
22d. ADDRESS Walker Ave. Pikesville, Md. 21208					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/7/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR MAR 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03305

CERTIFICATE OF DEATH

03297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. LENGTH OF STAY IN 16 <u>40 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hereford Rd.</u>		d. STREET ADDRESS <u>Hereford Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>P. W. Ade</u> First Middle Last <u>PALMER</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>FEB. 5, 1905</u>
9 AGE (in years last birthday) <u>62</u> yrs.		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weighmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Balto. Co., Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Herbert Calvin Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Emma H. Hunt</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>213-01-1001</u>	
17 INFORMANT <u>Mrs. E. Madeline Palmer</u> Address <u>Monkton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the prostate</u> 171X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>MAR. 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR. 7, 1967</u> , and that death occurred at <u>6:15</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/8/67</u>
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Meth. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>White Hall R.D. Md.</u>
24. FUNERAL DIRECTOR <u>J. Jacob Hartenstein, New Freedom Pa.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03306

CERTIFICATE OF DEATH

03298

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
c. LENGTH OF STAY in lb 10 days		d. STREET ADDRESS 11 McCormick Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Russell James Palmer		4. DATE OF DEATH Month March Day 15 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-29-98
9 AGE (In years last birthday) 68 yrs		10 IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (County & State, or foreign country) Uniontown, Md.		12. CITIZENSHIP OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Palmer		14. MOTHER'S MAIDEN NAME Ada Willett	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-09-3902A	
17. INFORMANT Anna Palmer		Address 11 McCormick Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. Myocardial Infarction IMMEDIATE CAUSE (a) 4201 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 4, 1967 to March 15, 1967 , that (I) (we) last saw the deceased alive on March 15, 1967 , and that death occurred at 2:00AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Jaime Ambrad</i>		22b. DATE SIGNED March 15, 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Ambrad		22d. ADDRESS 7620 York Road- Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/17/67	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	23d. LOCATION (City or Town) (County) (State) 4400 BELAIR RD MD
24. FUNERAL DIRECTOR DIPPEL BROS INC		25a. REC'D BY REGISTRAR 17 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20M 1/65

03307

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Item #9 per teleph. conv. with chart. 3/29/67 pc

03299

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>6 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>Rt 2 Bay 404 Sherwood Rd.</u>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Iva Elizabeth Parker</u> First Middle Last		4. DATE OF DEATH <u>March 22 1967</u> Month Day Year		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-16-01</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick County, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. MOTHER'S MAIDEN NAME <u>Shorb</u>	
13. FATHER'S NAME <u>John Bossler Moser</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-09-4165</u>	
17. INFORMANT <u>A. Frank Parker, Owings Mills, Md</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intercurrent respiratory infection</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Recurrent carcinoma ovary, ascites, bone marrow depress</u> DUE TO (c) <u>Carcinoma of ovary</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13th 1967</u> to <u>March 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 22th 1967</u> , and that death occurred at <u>10⁴⁰ PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Doherty</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dora C Kuwilsky</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>March 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens Finksburg Maryland</u>	
23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR <u>H. J. Eichardt</u>		ADDRESS <u>Owings Mills, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>					

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03308

CERTIFICATE OF DEATH

03300

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holly Hill Manor		d. STREET ADDRESS 5515 Sefton Ave.	
3. NAME OF DECEASED (Type or print) First Sarah Middle A. Last Parker		4. DATE OF DEATH Month 3 Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1891
9. AGE (In years, last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry vonGerlach		14. MOTHER'S MAIDEN NAME Anna Plummer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Ann L. Streett, 503 Fairway Ct. #4		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 2 , 19 67 , to March 11 , 19 67 , that (I) (we) last saw the deceased alive on March 11 , 19 67 , and that death occurred at 8:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Laurence E. Post		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LAURENCE E. Post		22d. ADDRESS 6805 York Rd - Baltimore 21212 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/14/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.		25a. REC'D BY REGISTRAR DATE MAR 14 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03309

CERTIFICATE OF DEATH

03301

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN IT <u>16 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>309 Alabama Road</u>		d. STREET ADDRESS <u>309 Alabama Road</u>	
3. NAME OF DECEASED (Type or print) <u>Robert S. Parr</u>		4. DATE OF DEATH <u>March 21</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OF HAIR <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 January 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coffee</u>	9. AGE (In years last birthday) <u>84</u> yrs
11. BIRTHPLACE (Country & State, or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT S. PARR</u>		14. MOTHER'S MAIDEN NAME <u>BELLE BIBB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>wife</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Baltimore</u> <u>Md.</u> <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>March 1967</u> to <u>March 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1967</u> and that death occurred at <u>5A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Walter T. Kees</u>		22b. DATE SIGNED <u>21 March 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER T. KEES</u>		22d. ADDRESS <u>Cockeyville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-24-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REGD BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

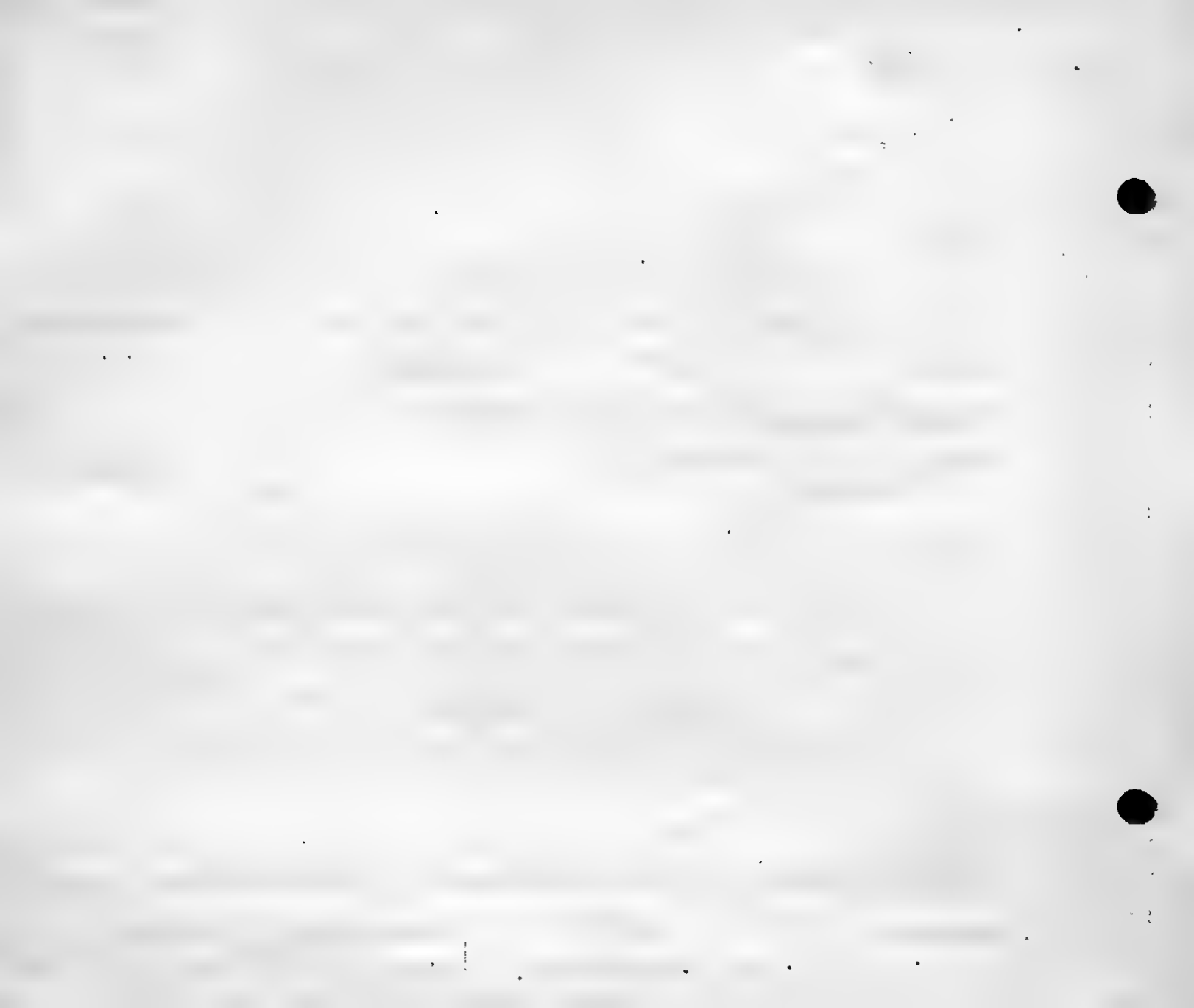
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>03310</div> <div>03302</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>rural Baltimore 21</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>rural Baltimore 11</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>16 A. Westway South</i>						d. STREET ADDRESS <i>16 A. Westway South</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>A.</i> Last <i>Plarr</i>						4. DATE OF DEATH Month <i>March</i> Day <i>16,</i> Year <i>19 67</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/31/1896</i>		9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Dentist Office</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Charles Spearman</i>						14. MOTHER'S MAIDEN NAME <i>Mary Bohs</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y= yes, or unknown) (If yes give year or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-32-2709 A</i>		17. INFORMANT <i>Agnes Morlock 16 A. Westway South</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
<div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i></div> <div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div> <div>DUE TO (b) <i>Hypertensive Cardiovascular Disease 7 Episodes</i></div> <div>DUE TO (c) <i></i></div> </div> </div> </div>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Theo C Patterson</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>3/17/67</i>		
NAME (Type) <i>THEO. C PATTERSON</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						22b. DATE THEREOF <i>3/18/1967</i>			22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial</i>		
23. FUNERAL DIRECTOR <i>John A. Moran Inc.</i>						ADDRESS <i>3000 E. Baltimore St.</i>			24a. REC'D BY REGISTRAR <i>Charles Judge</i>		
						24b. REGISTRAR'S SIGNATURE			DATE <i>MAR 21 1967</i>		

MEDICAL CERTIFICATION



1
M
I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03311

CERTIFICATE OF DEATH

03303

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d STREET ADDRESS 5 West Chesley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice G Phelps				4. DATE OF DEATH Month Day Year March 4, 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1890	9 AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Kohlhafer				14 MOTHER'S MAIDEN NAME Annie Kahl			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 220-14-3321		17 INFORMANT Address Mrs Carrie Tayman 7522 Kenlea Avenue 36			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute generalized peritonitis 3401 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) perforated gastric ulcer DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (A) (this hospital) attended the deceased from February 21, 1967 , to March 4, 1967 that we (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 8:40 a.m. from causes and on the date stated above.							
22a. SIGNATURE <i>Lawrence F. Misanik</i>						22b. DATE SIGNED March 4, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M. D.			22d. ADDRESS 7620 York Road, Towson 4, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-7-1967	23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR Lorraine Funeral Home 7401 Belair Road			25. DEED BY REGISTRAR DATE MAR 8 1967		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>		

51.

III



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03312

03304

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY _____		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c LENGTH OF STAY IN 1b 68 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL			d STREET ADDRESS 2920 WINDSOR AVENUE		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First LESTER Middle FRANKLIN Last PIERSON			4 DATE OF DEATH Month MARCH Day 5 Year 19 67		
5 SEX MALE	6. COLOR OR RACE NEGRO	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUGUST 9, 1920	9 AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b KIND OF BUSINESS OR INDUSTRY GOV'T		11 BIRTHPLACE (County & State, or foreign country) HOWARD COUNTY, MD.	
13 FATHER'S NAME HARRY F. PIERSON			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			14. MOTHER'S MAIDEN NAME LEATHA JACKSON		
16. SOCIAL SECURITY NO. 212 16 08 47		17 INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) HEMORRHAGE MASSIVE DUE TO (b) CARCINOMA, FLOOR OF MOUTH DUE TO (c) ASPIRATION PNEUMONIA					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) _____ (County) _____ (State) _____		
21. I certify that (1) (this hospital) attended the deceased from DEC. 27 , 19 66 , to MARCH 5 , 19 67 that (1) (we) lost the deceased alive on MARCH 5 , 19 67 , and that death occurred at 125A M, from causes on and on the date stated above.					
22a SIGNATURE <i>Milton Ginsberg</i>			22b. DATE SIGNED 3/6/67		
22c PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.			22d ADDRESS VAH FORT HOWARD, MARYLAND		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 3/9/67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d LOCATION (City or Town) _____ (County) _____ (State) _____		
24 FUNERAL DIRECTOR William C. March Funeral Home		25a REC'D BY REGISTRAR DATE MAR 8 1967	25b REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		

228 E. North Ave. Baltimore, Md.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03313 CERTIFICATE OF DEATH 03305

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>15 Milgate Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> d. STREET ADDRESS <u>15 Milgate Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>MAT</u> Last <u>POE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1920</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Owings Mills, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Edward Whitcomb</u>	
14. MOTHER'S MAIDEN NAME <u>Grace Reck</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-24-8865</u>		17. INFORMANT <u>Mr. G. Marvin Poe, 15 Milgate Rd., Mills, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - gastric</u> DUE TO <u>Metastasis to Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year 6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 25, 1966</u> to <u>March 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1967</u> , and that death occurred at <u>9:21 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>C.E. McWilliams</u> M.D.		22b. DATE SIGNED <u>3-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C.E. McWilliams, M.D.</u>		22d. ADDRESS <u>Peisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal Cem., Owings Mills, Md.</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Eckhardt</u>		25. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 23 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
20 M 1/66

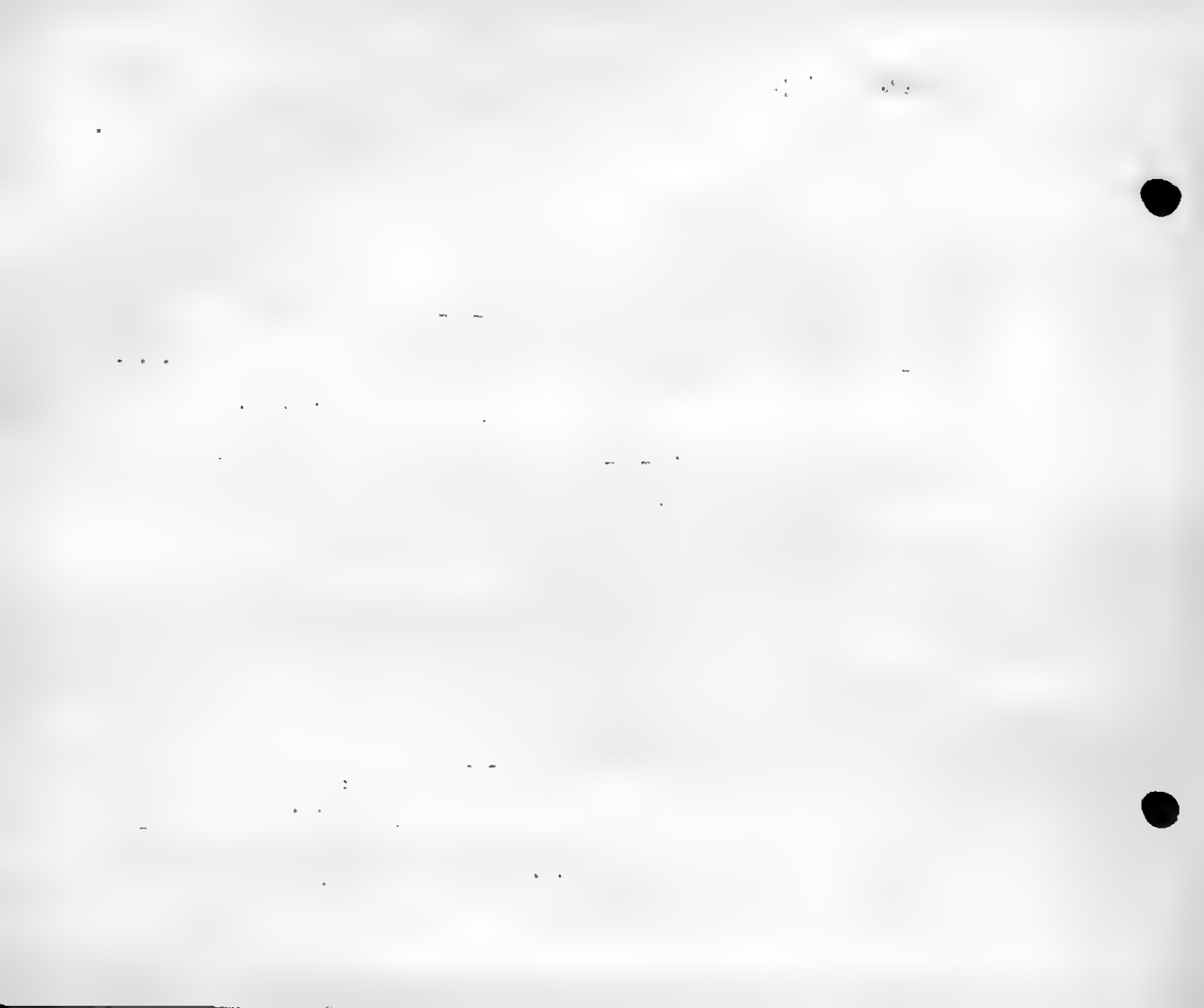
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03314

03306

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		d. STREET ADDRESS Manor Road	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Adam Popp		4 DATE OF DEATH Month Day Year March 6 1967	
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-17-82
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor - retired		10b KIND OF BUSINESS OR INDUSTRY Water Supply	9 AGE (In years) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN POPP		14. MOTHER'S MAIDEN NAME RACHEL GREEN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 213-38-8245	17. INFORMANT Address Records: Spring Grove State Hospital
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 2-1-67 , 19 to March 6 , 19 67 that (X) (we) last saw the deceased alive on March 6 , 19 67 , and that death occurred at 9:30 a.m., from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/9/67	23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEMETERY	23d. LOCATION (City or Town) (County) (State) PROVIDENCE BALTO. MD.
24. FUNERAL DIRECTOR John Bruno Somo		25a. REC'D BY REGISTRAR MAR 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03315					03307						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY <u>BALTIMORE</u>					a. STATE <u>Md</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY <u>BAITC.</u>						
<u>CATONSVILLE</u>					<u>CATONSVILLE</u>						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
					<u>CATONSVILLE</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
<u>1505 KENT AVE.</u>					<u>1505 KENT AVE.</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<u>MARY</u>		<u>M.</u>		<u>PRUITT</u>		Month <u>3</u> Day <u>26</u> Year <u>1967</u>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. FUNERAL YEAR	
<u>F</u>		<u>W</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>JULY 6, 1909</u>		<u>57</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
<u>SEANASTRESS</u>								<u>Maryland</u>			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<u>John W. Frey</u>						<u>MARGARET COLLINS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT Address			
<u>NO</u>						<u>213A49407</u>		<u>William H. PRUITT 1505 Kent Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<u>Myocardial Infarction</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<u>Diabetes mellitus Adult. Severe</u>	
DUE TO (b)										<u>10 years.</u>	
DUE TO (c)										<u>Essential Hypertension</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED	
Hour a.m. <u>19</u> p.m.										While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
<u>3/27/67</u>										<u>3/26/67</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/27/67</u> to <u>3/26/67</u> , that (I) (we) last saw the deceased alive on <u>3/27/67</u> , and that death occurred <u>3:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W E McCreth MD</u>										22b. DATE SIGNED <u>3/27/67</u>	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	
<u>W E McCreth MD</u>										<u>1303 Frederick Rd Catonsville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
<u>BURIAL</u>			<u>3/30/67</u>		<u>Good Shepherd</u>			<u>Howard Co Md.</u>			
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR	
<u>E S Mac Nabb 301 Frederick Rd Balto 28 Md</u>										<u>MAR 29 1967</u>	
										25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

03316

CERTIFICATE OF DEATH

03308

1 PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Baltimore</i>		c. LENGTH OF STAY IN 1b <i>Rural Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>6210 Haddon Ave.</i>		d. STREET ADDRESS <i>6210 Haddon Ave.</i>	
3 NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>J. B.</i> Last <i>Pugh</i>		4 DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>19 67</i>	
5 SEX <i>male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>8-12-1895</i>
9 AGE (in years last birthday) <i>71</i> yrs		10 IF UNDER 1 YEAR Months <i>71</i> Days <i>71</i> Hours <i>71</i> Min <i>71</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C & P Tel. Co.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>212100371A</i>	
17 INFORMANT <i>Catherine A. Pugh</i>		Address <i>same</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i> 3d DUE TO (b) <i>Carcinoma of Hypopharynx</i> 1 1/2 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>66</i> , to <i>28 Mar</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>28 Mar</i> , 19 <i>67</i> and that death occurred at <i>11:30 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>George J. Richards</i>		22b. DATE SIGNED <i>3/29/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>George J. Richards</i>		22d. ADDRESS <i>Greater Balt. Med. Center Balt 21204</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE OF BURIAL <i>4/1/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 30 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03317

CERTIFICATE OF DEATH

03309

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 110 days		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines-Catonsville		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Howe		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) Estelle E. Rackensperger		4 DATE OF DEATH Month March Day 1 Year 1967		5 SEX F		6 COLOR OR RACE Cauc.		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH June 4, 1887		9 AGE (In years last birthday) 79 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Virginia		11 BIRTHPLACE (County & State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Thomas Fletcher		14 MOTHER'S MAIDEN NAME Unk.		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Mrs. Frank C. McShane 810 W. Stayman Dr - Ellicott City-Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphatic Leukemia DUE TO 1221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH									
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from Mar 20, 1967 to Mar 1, 1967 , that (I) (we) last saw the deceased alive on Mar 1, 1967 , and that death occurred at 6:15 PM , from causes and on the date stated above		22a SIGNATURE Harry A. Knipp		22b DATE SIGNED Mar 3, '67		22c PHYSICIAN'S NAME (Type) Harry Knipp, M. D.		22d ADDRESS 4116 Edmondson Av.		22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3-4-67		23c NAME OF CEMETERY OR CREMATORY Western Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore, Md.		24 FUNERAL DIRECTOR Witzke F.D. - 4101 Edmondson Ave.		25a REC'D BY REGISTRAR MAR 6 1967		25b REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03318 Item #11 Film #0300 3/2/67 pg 03310									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b MARYLAND				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Summit Nursing Home					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City				
3. NAME OF DECEASED (Type or print) First HULDA Middle RADHE Last 4. DATE OF DEATH Month March Day 3 Year 1967					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1891		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ? unknown		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME ?					14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-44-9316 A		17. INFORMANT S.G. Radhe, 2 Darvel Circle, Ellicott City					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 3561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) AMYOTROPHIC LATERAL SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH 6 M
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 12-28 , 1966 to 3-3 , 1967 , that (I) (we) last saw the deceased alive on FEB. 28 , 1967 , and that death occurred at 2:22 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Peter J. Hinch					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-3-67		
22c. PHYSICIAN'S NAME (Type) F.C. Higinbotham					22d. ADDRESS Ellicott City, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR F.C. Higinbotham					25a. REC'D BY REGISTRAR Charles Judge				
25b. REGISTRAR'S SIGNATURE Charles Judge					DATE MAR 6 1967				



FOR STATE
HEALTH DEPT

03319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03311

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b ////////	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital Northwestern Blvd. & York & Raven		e. STREET ADDRESS 111 Elm Ave.	
3 NAME OF DECEASED (Type or print) Charles Lee Rains		4 DATE OF DEATH Month 3 Day 16 Year 19 67	
5 SEX M		6 COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 12/23/10	
9 AGE (In years last birthday) 56 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY Construction	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Rains		14. MOTHER'S MAIDEN NAME Mary Kouba	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 217-24-6896	
17 INFORMANT Mr. Lee Rains (son)		18 ADDRESS 1007 Rosedale Ave. Glen Burnie, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4301 IMMEDIATE CAUSE (a) 4301 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. 4301 2		INTERVAL BETWEEN ONSET AND DEATH 4301	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		22. DATE SIGNED 3/16/67	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF March 20/67	
23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.		23d LOCATION (City or Town) (County) (State) Taylor Ave. Balto., Md.	
24 FUNERAL DIRECTOR Singleton Funeral Home		25a REC'D BY REGISTRAR DATE Mar 20 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

03320

CERTIFICATE OF DEATH

03312

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 21204</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson 21204</u>	
c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>		d. STREET ADDRESS <u>512 Seminary Ave, East</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>512 E. Seminary Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Paul Frederick Redding</u>		4 DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1900</u>
9 AGE (in years lost birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Contracting</u>		11b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11c. BIRTHPLACE (County & State or foreign country) <u>Baltimore</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Redding</u>		14. MOTHER'S MAIDEN NAME <u>Eleanora Coker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212 09 9852</u>	
17. INFORMANT <u>Bruce Redding, Timonium, Md. 21093</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <u>1201</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>coronary sclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>one hr.</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1956</u> to <u>2/3, 1967</u> , that (I) (we) last saw the deceased alive on <u>2/3, 1967</u> , and that death occurred at <u>12:05</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William F. Renner</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm F. Renner</u>		22d. ADDRESS <u>3222 St. Paul St. Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>3, 6, 57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Baltimore, Md</u>	
24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03321

CERTIFICATE OF DEATH

03313

1 PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 RIDGE RD.</u>		d. STREET ADDRESS <u>8 RIDGE RD</u>	
3 NAME OF DECEASED (Type or print) <u>EMINA BELLE REED</u>		4. DATE OF DEATH <u>MARCH 16 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/84</u>
9 AGE (In years, last birthday) <u>82</u>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH W. LANKFORD</u>		14. MOTHER'S MAIDEN NAME <u>MARY MADDOX</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. ELSIE DOVE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4x100</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from <u>March</u> , 19 <u>62</u> to <u>March</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 21</u> , 19 <u>67</u> , and that death occurred at <u>6:45 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leo J. Gaver, M.D.</u>		22b. DATE SIGNED <u>March 17, 1967</u>	22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>
23d. LOCATION (City or Town) (County) (State) <u>BALTO. CC. MD.</u>		24 FUNERAL DIRECTOR <u>E.S. MALNAB</u>	
25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03322

CERTIFICATE OF DEATH

03314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21204		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1644 Naturo Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grace Margaret REITZEL				4. DATE OF DEATH Month Day Year March 1, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1906		9. AGE (In years last birthday) 60 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ? McGuiness				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 218-05-3090		17. INFORMANT Mr. Samuel S. Reitzel Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 1, 1967 , to March 1, 1967 , that (I) (we) last saw the deceased alive on March 1, 1967 , and that death occurred at 12:40M , from causes and on the date stated above.							
22a. SIGNATURE Teodoro Paglinauan, Jr.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 1, 1967	
22c. PHYSICIAN'S NAME (Type) Teodoro Paglinauan, Jr. M.D.			22d. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/4/67.		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE MAR 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

03323

Item #12 Filed April 4/5/67

CERTIFICATE OF DEATH

03315

<p>1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1116 KENT AVE.</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>1116 KENT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR N. Richardson</u></p>				<p>4. DATE OF DEATH Month Day Year <u>MAR 28 1967</u></p>			
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>11-27-1879</u></p>	
<p>9. AGE (In years last birthday) <u>87</u> yrs.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>London England</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>				<p>13. FATHER'S NAME <u>Edward Richardson</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Emily BOBB</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO. <u>?</u></p>				<p>17. INFORMANT <u>T.D. Nichols</u> Address <u>1116 KENT AVE. CATONS 28, MD.</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Insufficiency</u> DUE TO (c) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>							<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>March 19 67</u> to <u>March 28 1967</u>, that (I) (we) last saw the deceased alive on <u>March 19 67</u>, and that death occurred at <u>M</u>, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Thos T. Abbott</u></p>				<p>22b. DATE SIGNED</p>		<p>22c. PHYSICIAN'S NAME (Type) <u>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></u></p>	
<p>22d. ADDRESS</p>				<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>			
<p>23b. DATE THEREOF <u>3-31-67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>ELK RIDGE MD.</u></p>			
<p>24. FUNERAL DIRECTOR <u>F.C. Higginbotham</u> ADDRESS <u>ELICOTT CITY, MD.</u></p>				<p>25a. REC'D BY REGISTRAR <u>MAR 31 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03324

CERTIFICATE OF DEATH

Reg. Dist. No.

03316

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 2 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 KINSHIP ROAD				d. STREET ADDRESS 69 NORTHSHIP ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET EUGENIA RILEY				4. DATE OF DEATH Month Day Year MARCH 21, 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1911		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROFESSIONAL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE X. RILEY				14. MOTHER'S MAIDEN NAME MARGARET MORRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 214-38-3746		17. INFORMANT PAUL RILEY Address 2967 LIBERTY PARKWAY DUNDALK, MD. 21222			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on March 21, 1967 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 DUNDALK AVE. DUNDALK 21222, MD. DATE SIGNED 3/23/67							
ACTUAL SIGNATURE Benigno R. Nazario M.D.							
PHYSICIAN'S NAME (Type) BENIGNO R. NAZARIO, MD.		DUNDALK 21222, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/24/67		22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE MEMORIAL		22d. LOCATION (City, town, or county) (State) DORSEY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER BROOKS BRADLEY, INC., DUNDALK				24a. RECEIVED BY REGISTRAR MAR 27 1967		24b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03325

03317

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN TB <u>Six Months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>711 Fairway Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>711 Fairway Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Ringger</u> First Middle Last 4. DATE OF DEATH <u>March 22, 1967</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 20, 1890</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ernest Remler</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>216-16-5820</u> 17. INFORMANT <u>Marcella R. Kempf (Daughter)</u> Same Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CAREINOMATOIDS</u> <u>(CA - Kidney)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>102</u> DUE TO (c) <u>8 mos.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1966</u> to <u>MARCH 22 1967</u> that (I) (we) last saw the deceased alive on <u>3-22-1967</u> and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Dr. S. J. Venable, Jr.</u> 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED <u>3-22-67</u> 22d. ADDRESS <u>7215 York Road, Baltimore Md 21224</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 25, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Eugenia K. Seitz</u> ADDRESS <u>5209 York Road, Seitz Funeral Home Baltimore, Md. 21212</u> 25a. REC'D BY REGISTRAR <u>MAR 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03326

CERTIFICATE OF DEATH

03318

1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HALL
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS ---	
3 NAME OF DECEASED (Type or print) First WALTER Middle P. Last RITZMANN		4 DATE OF DEATH Month MARCH Day 19 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JUNE 18, 1907
9 AGE (In years last birthday) 59 yrs		10 IF UNDER 1 YEAR Months 19 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b KIND OF BUSINESS OR INDUSTRY Paper mill	11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME JOSEPH F. RITZMANN	
14 MOTHER'S MAIDEN NAME CATHERINE STRIETMALLER		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II	
16 SOCIAL SECURITY NO 217 14 19 89		17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RIGHT LUNG WITH METASTASIS 16.3 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (if in this hospital) attended the deceased from 3/18/67 , 19 67 , to 3/19/67 , 19 67 , that (s) (we) last saw the deceased alive on 3/19/67 , 19 67 , and that death occurred at 8:45 PM , from causes and on the date stated above			
22a SIGNATURE <i>Peter V. Juvan</i>		22b DATE SIGNED 3/20/67	
22c PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 3/22/67	23c NAME OF CEMETERY OR CREMATORY WISEBURG CEMETERY	23d LOCATION (City or Town) (County) (State) WHITE HALL, MARYLAND
24 FUNERAL DIRECTOR <i>Jacob Hartenstein</i>		25a REC'D BY REGISTRAR MAR 23 1967	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03327

03319

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u> c. LENGTH OF STAY IN 1b <u>14R. 3 mo. 26d.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>7 PROSPECT CIRCLE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>H.</u> Middle <u>MAY</u> Last <u>Robbins</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1967</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/25/1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.		10. FUNDER 1 YEAR Months <u>9</u> Days <u>2</u>		11. FUNDER 24 HRS. Hours <u>13</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>CANADA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Alfred HUGHES</u>								14. MOTHER'S MAIDEN NAME <u>C. VAN Duser</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>140-18-3728</u>				17. INFORMANT <u>Mrs HUDGINS</u>				Address <u>1643A WAVERLY WAY LOCH RAVEN APT. #12</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>460A</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis Generalized</u>												INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 3, 1965</u> , to <u>March 2, 1967</u> , that (1) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.																	
22a. SIGNATURE <u>David J. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED <u>March 2-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>David J. Miller</u>				22d. ADDRESS <u>Linson Rd. - Owings Mills, Md</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>3/2/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>West Long Branch, N. J.</u>							
24. FUNERAL DIRECTOR <u>Wm. F. Tichner & Sons</u> ADDRESS <u>Balto. Md.</u>																	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>												25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>MAR 2 1967</u>																	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03328

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03320

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1512 York Road				d. STREET ADDRESS 1512 York Road			
3. NAME OF DECEASED (Type or print) First Loretta Middle M. Last Rockel				4. DATE OF DEATH Month 3 Day 24 Year 1967			
5. SEX Female	6. CO. OR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1890	9. AGE (in years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
13. FATHER'S NAME Trainer			14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOC. SEC. NO.		17. INFORMANT Mr. Roland A. Rockel Address 16 W. Seminary Ave. Lutherville, Md.		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Cerebral DUE TO Sudden (b) Arteriosclerotic Cardiac DUE TO Renal Vascular Disease (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Not of natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell, M.D.			22. DATE SIGNED 3/24/67				
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.			Address (Street city town, or county)				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/1967	23c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery		23d. LOCATION (City or Town) (County) (State) Rockyville, Md.		
24. FUNERAL DIRECTOR Wm. Fickman & Sons			Address Baltimore, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03329

CERTIFICATE OF DEATH

03321

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3511 Foxcliff Court, Apt 104</u>		d. STREET ADDRESS <u>3511 Foxcliff Court, Apt 104</u>	
3. NAME OF DECEASED (Type or print) <u>Nathan Rosen</u>		4. DATE OF DEATH <u>March 22, 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1906</u>
9. AGE (n years lost birthday) <u>60</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILLINERY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB ROSEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>090-07-2984</u>	
17. INFORMANT <u>Mrs. Toby Rosen, 3511 Foxcliff Court Apt 104</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u></u>		INTERVA. BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u> <u>15 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1952</u> to <u>MAR 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAR 17, 1967</u> , and that death occurred at <u>11 P. M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Albert J. Himelfarb</u>		22b. DATE SIGNED <u>3/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT J. HIMELFARB</u>		22d. ADDRESS <u>3501 ST. PAUL ST. BALTO Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/24/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETH EL MEMORIAL PARK</u>		23d. LOCATION (City or town) (County) (State) <u>RANDALLSTOWN, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03330					03322				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY BALTIMORE MARYLAND					a. STATE MD. b. COUNTY BALTIMORE				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - TOWSON 21204					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GBMC					d. STREET ADDRESS 400 EAST 28th ST.				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First SEBASTIAN Middle ROSSKOPF Last ROSSKOPF					Month MAR. Day 3 Year 1967				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/13/00		9. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OWNER		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) BAVARIA GERMANY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME SEBASTIAN, ROSSKOPF					14. MOTHER'S MAIDEN NAME FRANCISCA MYERS MAYER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE			16. SOCIAL SECURITY NO. 219-32-0758		17. INFORMANT Address MRS. ROSA ROSSKOPF (SAME)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. OATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Ca Lung 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of lung with metastases (c) metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 2, 1967 to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 1:45 PM , from the causes and on the date stated above.									
22a. SIGNATURE Ram K. Chhillar					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-2/3/67		
22c. PHYSICIAN'S NAME (Type) RAM K. CHHILLAR					22d. ADDRESS CTR. BALTO. MED. CENTER BALTIMORE, MD. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/6/1967		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City, town or county) (State) Anne Arundel Cty. Md.		
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.					25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03331

03323

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore-Rural		c. LENGTH OF STAY IN 1b Baltimore, --Rural		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 814 Old North Point Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ANITA		First		Middle RULENZ		Last		4. DATE OF DEATH March 5,		Month		Day		Year 1967									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1881		9. AGE (in years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME John Tiess								14. MOTHER'S MAIDEN NAME Minnie Buodowski															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No								16. SOCIAL SECURITY NO. Mrs. Anna R. McColligan								17. INFORMANT 814 Old North Point Road							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arterio-sclerosis - Cardio Vascular Disease																INTERVAL BETWEEN ONSET AND DEATH 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June 1965 , to March 5, 1967 , that (I) (we) last saw the deceased alive on March 5, 1967 , and that death occurred at 11 P.M. from the causes and on the date stated above.																							
22a. SIGNATURE Morris A. Jacobs								22b. DATE SIGNED															
22c. PHYSICIAN'S NAME (Type) Morris A. Jacobs, M.D.								22d. ADDRESS 1010 North Point Road,															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Mar. 8, 1967				23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d. LOCATION (City, town or county) (State) Colgate, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.								25. REC'D. BY REGISTRAR MAR 13 1967								25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03332

CERTIFICATE OF DEATH

03324

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Parkville) Balto. 21234</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7613 Old Harford Road St. Joseph's Hosp.</u>		d. STREET ADDRESS <u>7613 Old Harford Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Sakellarakos</u> Last <u>Sakellarakos</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1893.</u>
9. AGE (In years last birthday) yrs <u>73</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Stavros Nikolopoulos</u>		14. MOTHER'S MAIDEN NAME <u>Athena Panagiotopoulos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>102-07-7461B</u>	
17. INFORMANT <u>Mr. Peter Sakell</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral heart disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> to <u>March 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1967</u> , and that death occurred at <u>8 P.</u> M, from causes on and the date stated above.			
22a. SIGNATURE <u>R Donald Jaudorf</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3-11-67</u>
22c. PHYSICIAN'S NAME (Type) <u>R Donald Jaudorf</u>		22d. ADDRESS <u>6677 Harford Rd</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/13/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03334

CERTIFICATE OF DEATH

03326

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 15 Delight Avenue	
3. NAME OF DECEASED (Type or print) First FONTELLA Middle L. Last SAMPLES		4. DATE OF DEATH Month March Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1900.
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 1 Days 28 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mills		14. MOTHER'S MAIDEN NAME Mary E. Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Charles Sommers		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Disease 4351 DUE TO (b) Terminal Ventricular Arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Fibrillation			INTERVAL BETWEEN ONSET AND DEATH None
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June, 1967 to 28 Mar 1967 that (I) (we) last saw the deceased alive on 28 Mar 1967 , and that death occurred at 2:40 M, from causes and on the date stated above.			
22a. SIGNATURE John C. Hyle		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN C. HYLE		22d. ADDRESS 7527 Belvidere Blvd 36	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/67.	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	23d. LOCATION (City or Town) (County) (State) Kansas City, Missouri.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DAMAR 30 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03335

CERTIFICATE OF DEATH

03327

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY — ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 5 DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d STREET ADDRESS 1608 ELLSWORTH STREET	
3 NAME OF DECEASED (Type or print) First WALTER Middle DOUGLAS Last SANDERS		4 DATE OF DEATH Month MARCH Day 5 Year 1967	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH SEPTEMBER 5, 1905
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b KIND OF BUSINESS OR INDUSTRY LABORER	
11 BIRTHPLACE (Country & State, or foreign country) BALTIMORE, MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME CHARLIE SANDERS		14 MOTHER'S MAIDEN NAME ELIZABETH TATE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16 SOCIAL SECURITY NO. —	
17 INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) PSEUDOMONAS AERUGINOSA DUE TO (c) —	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) THROMBOSIS OF THE RIGHT MIDDLE CEREBRAL ARTERY. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year Hour — o.m. 19 p.m.		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)	
21 I certify that WALTER DOUGLAS SANDERS (this hospital) attended the deceased from FEB 28 , 19 67 , to MARCH 5 , 19 67 , that ✓ (we) lost ✓ saw the deceased alive on MARCH 5 , 19 67 , and that death occurred at 150P M, from causes on and on the date stated above.			
22a SIGNATURE <i>Peter V. Juvan</i>		22b DATE SIGNED 3/6/67	
22c PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d ADDRESS VAH FORT HOWARD, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 3-9-67	23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24 FUNERAL DIRECTOR RAYNOR SANDERS		25a REC'D BY REGISTRAR MAR 13 1967	
FUNERAL HOME, 217 E. Preston ST, Baltimore		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03336				CERTIFICATE OF DEATH				03328			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b <u>1000</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford MANOR Nursing Home</u>				d. STREET ADDRESS <u>3800 Liberty Hts.</u>							
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>A</u> Last <u>SARUBIN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>11</u> Year <u>1967</u>				IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1903</u>		9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Pechal</u>				14. MOTHER'S MAIDEN NAME <u>Hinda ?</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>ATAALLAH GOLPIRA, MD. - 1942 CEDAR LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon with wide spread metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>66</u> , to <u>March 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 9</u> , 19 <u>67</u> , and that death occurred at <u>2:35</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Atallah Golpira</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>March 11, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>ATAOLLAH GOLPIRA</u>				22d. ADDRESS <u>1942 Cedar Lane, Balto, Md. 21222</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/12/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Yeshu Cong</u>		23d. LOCATION (City, town or county) (State) <u>Balto Md.</u>					
24. FUNERAL DIRECTOR <u>Sol Korman & Bros Inc</u>				ADDRESS <u>6010 Reisterstown Rd</u>				25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (1)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #0 Film #3333 3/9/67 pv

03337

CERTIFICATE OF DEATH

03329

1 PLACE OF DEATH a. COUNTY Baltimore		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. #21204		d. STREET ADDRESS 4312 Walther Avenue #21214	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle M. Last SCHAFER		4. DATE OF DEATH Month 3- Day 5 Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-23-95
9 AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Durham		14. MOTHER'S MAIDEN NAME Lottie Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 183-05-2682	
17 INFORMANT Miss Phyllis Schafer-Daughter		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar artery thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 3-4- , 19 67 , to 3-5-67 , 19 67 , that (X) (we) last saw the deceased alive on 3-5- , 19 67 , and that death occurred at 19:00 , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence J. Misanik</i>		22b. DATE SIGNED 3-5-67	
22c. PHYSICIAN'S NAME (Type) Lawrence Misanik, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/8/67	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #1h		25a. REC'D BY REGISTRAR DAVID R 6 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

03338

CERTIFICATE OF DEATH

03330

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>53 Briarwood Rd.</u>				d STREET ADDRESS <u>53 Briarwood Rd.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Theckla</u> Middle <u>C.</u> Last <u>Schifferer</u>				4 DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 18/82</u>		9 AGE (n years last birthday) <u>84</u> yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Frederick Schifferer</u>				14 MOTHER'S MAIDEN NAME <u>Katherine ---</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>212-32-4176A</u>		17 INFORMANT <u>Mrs. Eileen E. Eiser</u> Address <u>53 Briarwood Rd. - 21228</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour 'o m p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>66</u> to <u>3/15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3/9</u> 19 <u>67</u> , and that death occurred at <u>4:35</u> M, from causes and on the date stated above							
22a SIGNATURE <u>Robert A. Reiter</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>3/16/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Robert A. Reiter, M.D.</u>				22d ADDRESS <u>606 Edmondson Ave</u> <u>21228</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>3-18-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Ellicott City, Md.</u>	
24 FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>				25a REC'D BY REGISTRAR DATE <u>MAR 17 1967</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

03331

03339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Baltimore		c. LENGTH OF STAY IN lb 1 year		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Augsburg Lutheran Home 6811 Campfield Road 21207		e. STREET ADDRESS 3010 Glendale Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Christina Middle Elizabeth Last Schilling		4 DATE OF DEATH Month March Day 4 Year 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/9/80		9 AGE (In years last birthday) 86 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Rehling		14. MOTHER'S MAIDEN NAME Barbara Rithman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-50-9423-01		17. INFORMANT Paul A. Hauer, 6811 Campfield Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease / Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho-pneumonia DUE TO (c) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 5 years 4 days 6 days			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterio Sclerotic Changes					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from Feb , 19 66 , to March 4 , 19 67 , that (I) (we) last saw the deceased alive on March 3 , 19 67 , and that death occurred at 11 P.M. from causes and on the date stated above.					
22a. SIGNATURE Earl L. Chambers		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/5/67	
22c. PHYSICIAN'S NAME (Type) Earl L. Chambers		22d. ADDRESS 4108 Liberty St - Balto - Md			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 3/1/67		23c. NAME OF CEMETERY OR CREMATORY Western Cove	
23d. LOCATION (City or town) (County) (State) Balto Md					
24. FUNERAL DIRECTOR W. Keenmann 6062 Bay Rd		25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03340

03332

1 PLACE OF DEATH a. COUNTY 8811 Jasper Lane Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE 8811 Jasper Lane, Balto. Co., Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. LENGTH OF STAY IN tb lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8811 JASPER LANE		d. STREET ADDRESS 8811 JASPER LANE	
3 NAME OF DECEASED (Type or print) Elizabeth A. Schultz		4 DATE OF DEATH Month March Day 25 Year 1967	
5 SEX F	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-30-93
9 AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Edgar Bissell		14. MOTHER'S MAIDEN NAME Ruth Ann Roberts	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic sclerotic Cardiac vascular DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH undet.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1, 1964 , to 3-24, 1966 , that (I) was last saw the deceased alive on 3-23, 1967 and that death occurred at 6p M, from causes and on the date stated above			
22a SIGNATURE John C. Hyle		22b DATE SIGNED 3-27-67	
22c. PHYSICIAN'S NAME (Type) Dr. John C Hyle		22d. ADDRESS 7527 Belair Road	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 3/28/67	23c NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk	23d LOCATION (City or Town) (County) (State) Parkville, Balto., Md.
24 FUNERAL DIRECTOR CHARLES F EVANS & SON		25a REC'D BY REGISTRAR BALTO., Md. 2123	25b REGISTRAR'S SIGNATURE Charles F. Evans

MAR 29 1967

CERTIFICATE OF DEATH

03341

03333

1. NAME OF DECEASED
(Type or Print)

EDWARD L. SCHWARTZ

2. DATE AND HOUR OF DEATH

3-31-67

3. PLACE OF DEATH IN BALTIMORE-MARYLAND

BALTIMORE COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's
TOWSON - 21204

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admittance)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

903 S. Conkling St.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-1-1911

9. AGE (In years
last birthday)

55

Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

PBX Installer

10B. KIND OF BUSINESS OR INDUSTRY

C + P. Telephone Co.

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George E

14. MOTHER'S MAIDEN NAME

Mary Lober

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

212-05-0613

17. INFORMANT

Mrs. Thelma Schwartz

ADDRESS

903 S. Conkling St.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Coronary Occlusion

(B) DUE TO

Myocardial Infarct

(C)

INTERVAL BETWEEN
ONSET AND DEATH

II

22. I certify that (I) (this hospital) attended the deceased from March 25 1967 to March 31 1967 that (I) (we) last saw the deceased alive on March 31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Andrew Kuskowski

M.D.

Attending
Phys.

Med.
Director

Staff
Phys.

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

Andrew Kuskowski

M.D.

23D. ADDRESS

7529 Eastern Ave

21204

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

4-3-67

24C. NAME of CEMETERY or CREMATORY

Greenmount

24D. LOCATION

Balto Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 5 1967

25B. NAME OF REGISTRAR

Charles Judge

25C. FUNERAL DIRECTOR

Thelma A. Hoffman

ADDRESS

3218 Hudson St

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the funeral director. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03342

CERTIFICATE OF DEATH

03334

TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 45 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 406 MURDOCK ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last ALEXANDER SEAMON		4. DATE OF DEATH Month Day Year MARCH 20 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 19, 1878
9. AGE (In years and birthday) 89 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY TAILOR SHOP	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SEAMON		14. MOTHER'S MAIDEN NAME ANNA SHENDERMEISER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES VBO		16. SOCIAL SECURITY NO 217 03 66 74	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE. DECUBITIS, MULTIPLE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/3/67 , 19__, to 3/20/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/20/67 , 19__, and that death occurred at 11:00AM from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/22/1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE, NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR JENKINS FUNERAL HOME		25a. REC'D BY REG STRAR DATE MAR 21 1967	
		25b. REG STRAR'S SIGNATURE <i>Charles Juvan</i>	

2000



1000



1000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03343

CERTIFICATE OF DEATH

03335

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore TOWSON</u>		c. LENGTH OF STAY IN 1b <u>21204</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>721 Hickory Lot Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Amy</u> Middle <u>Moriva</u> Last <u>Searls</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1895</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Trenton, New Jersey</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>Edward Hart Giles</u>		16. MOTHER'S MAIDEN NAME <u>Anna Hurmston</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		18. SOCIAL SECURITY NO <u>717-07-69</u>	
19. INFORMANT <u>COL. WELLINGTON B. SEARLS</u> (Patients Chart)		Address <u>(SAME)</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fibrosarcoma of ovary, Rt. with</u> DUE TO (b) <u>Generalized metastasis</u> DUE TO (c) <u>1750.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH <u>15 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	22b. INJURY OCCURRED Where <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	22c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	22d. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Feb. 7, 1967</u> to <u>March 19, 1967</u> , that (we) last saw the deceased alive on <u>March 19, 1967</u> , and that death occurred at <u>4:40 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Shokya</u>		22b. DATE SIGNED <u>March 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Stuart Sunday</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 21 1967</u>	
ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03344

CERTIFICATE OF DEATH

03336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 years +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in The Pines - 16 Fusting Ave</u>				d. STREET ADDRESS <u>144 E. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH SCITZ</u>				4. DATE OF DEATH Month Day Year <u>3 6 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/1889</u>	9. AGE (In years last birthday) <u>77 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home - wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley E. Hahn</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Youngling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>George L. Stroup</u> Address <u>418 Apple Road, Carroll, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5-30-1964</u> to <u>3-6-1967</u> , that (I) (we) last saw the deceased alive on <u>3-6-1967</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Wilmer K. Gallagher Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3-6-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher Jr.</u>				22d. ADDRESS <u>6209 Frederick Ave. Baltimore 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>	23d. LOCATION (City or town)	(County)	(State)		
24. FUNERAL DIRECTOR <u>J. E. Myers Jr.</u>		ADDRESS <u>Westminster Md.</u>	25a. RECEIVED BY REGISTRAR <u>MAR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

03345

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03337

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb TOWSON 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1313 MILL DAM RD		d. STREET ADDRESS 1313 MILL DAM RD.	
3 NAME OF DECEASED (Type or print) GEORGE FREDERICK SEYBOTH		4 DATE OF DEATH Month MARCH Day 30 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-4-99
9 AGE (in years last birthday) yrs 67		10 F UNDER 1 YEAR Months 30 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die maker		10b. KIND OF BUSINESS OR INDUSTRY Black & Becker	
11 BIRTHPLACE (State or foreign country) Germany		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME George Seyboth		14. MOTHER'S MAIDEN NAME Rose Kuebler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 122-10-9867	
17 INFORMANT Mrs Adelaide L. Seyboth		Address 1313 Milldam Road	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 1801 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) CORONARY ARTERY DISEASE DUE TO (c) 6 mos.		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William A. Pillsbury		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md.	
24 FUNERAL DIRECTOR Lossal Williams Home 2401 Belair Road		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 3-30-67	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only deoxy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03338

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mary Dessel S. Chamberger		4 DATE OF DEATH Month March Day 28 Year 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/3/1890
9 AGE (in years and months) 76 yrs		10 UNDER 1 YEAR Months 1 Days 4 Hours 15 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Balto., Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Jacob Dessel		14. MOTHER'S MAIDEN NAME Mary Sauers	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO.	
17 INFORMANT Mrs. Elaine M. Peck		Address 322 Worthington Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suspected thrombosis DUE TO (b) Abdominal Aortic DUE TO (c) Hypertensive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Sudden 1 1/2 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		22. DATE SIGNED 3/28/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		Address (Street city town or county)	
23a. BURIAL, CREMATION Burial		23b. DATE THEREOF 3/31/67	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR APR 3 1967	
ADDRESS Balto., Md. 21212		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03347											
03339											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>						c. LENGTH OF STAY IN 1b <u>60 years</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 N. Kingsville, Maryland</u>						d. STREET ADDRESS <u>Kingsville, Md.</u>					
3. NAME OF DECEASED (Type or print) <u>Joseph Bradley Shepperd</u>						4. DATE OF DEATH <u>March 16 1967</u>					
5. SEX <u>M</u>		6. COLOR OF RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22, 1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Francis Clauden Shepperd</u>						14. MOTHER'S MAIDEN NAME <u>Mary Bradley Shepperd</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-22-7553</u>		17. INFORMANT <u>Regina B. Shepperd</u> Address <u>Kingsville Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Insufficiency</u> 4231 DUE TO (b) <u>Cardio Vascular CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA</u> 1962 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>March</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-13</u> 19 <u>67</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William B. Tyson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-16-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William B. Tyson</u>						22d. ADDRESS <u>Kingsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR 18 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST STEPHEN CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>BRADSHAW MD</u>			
24. FUNERAL DIRECTOR <u>THE DIPPEL BROS INC</u>						ADDRESS <u>7110 BELAIR ROAD</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03348

CERTIFICATE OF DEATH

03340

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Baltimore</u> b COUNTY <u>MD</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore General Hospital</u>		d STREET ADDRESS <u>5000 A Lombard Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Nathan</u> First <u>Shenitz</u> Middle Last		4 DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/18/75</u>
9 AGE (In years last birthday) <u>91</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Isidor</u>		14 MOTHER'S MAIDEN NAME <u>Hokawa</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>215-32-9424</u>	
17 INFORMANT <u>Mrs. Rosalie Racusin</u>		Address <u>3609 Briarstone Road</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cerebrovascular Insufficiency</u> (c) <u>6 days</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>67</u> , to <u>3/1</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>3/1</u> , 19 <u>67</u> , and that death occurred on <u>3/1</u> M, from causes on the date stated above.			
22a SIGNATURE <u>Dr. De Joya</u>		22b DATE SIGNED <u>3/1/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. De Joya</u>		22d ADDRESS <u>B. C. G. H.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>3/2/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Abnath Shalom</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24 FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25 REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03343

03341

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>27 WARREN PARK DRIVE</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>27 WARREN PARK DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) <u>ABRAHAM</u> First <u>SILBERMANN</u> Middle <u>1</u> Last		4. DATE OF DEATH <u>MARCH 10 1967</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 22, 1913</u>		9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>			
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>NOT KNOWN</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>C91-26-8011</u>		17. INFORMANT <u>MRS HENIA SILBERMANN</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> (b) <u>marked anemia</u> (c) <u>Chondrosarcoma, malignant</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>months</u> <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 21, 1966</u> to <u>March 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u>4 a.m.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis R. Maser</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/10/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>LOUIS R. MASER M.D.</u>		22d. ADDRESS <u>2724 SMITH AVE., BALTIMORE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent Cemetery</u>			
23d. LOCATION (City, town or county) <u>Baltimore</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis & Son, Inc.</u>		ADDRESS <u>1700 N. E. Avenue, N.Y.C.</u>		25a. REC'D BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>		DATE <u>MAR 10 1967</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03350

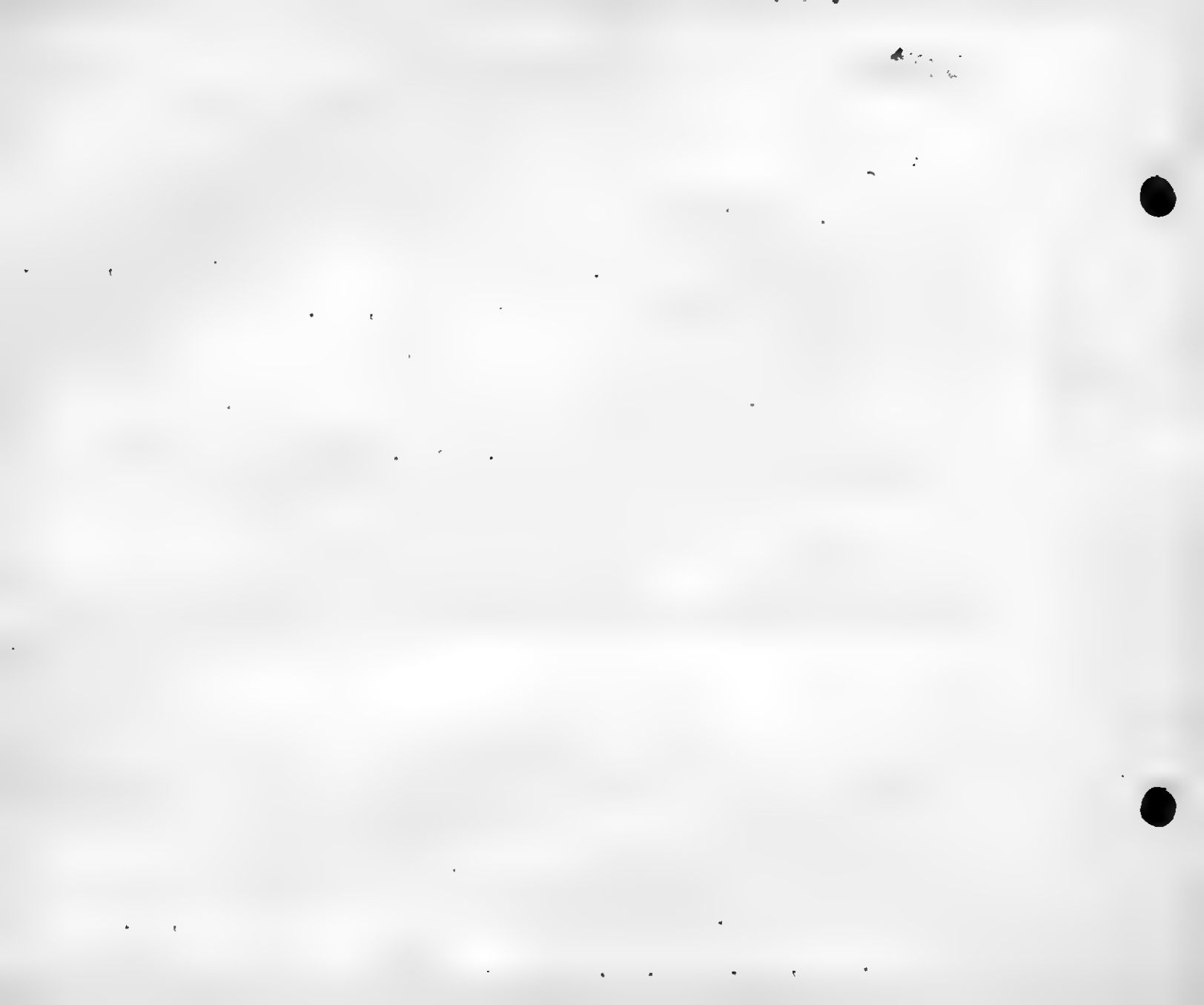
CERTIFICATE OF DEATH

03342

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle S. Last Sinclair		4. DATE OF DEATH Month March Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1895
9. AGE (in years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry F. Sinclair		14. MOTHER'S MAIDEN NAME Ann L. Wehn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO W W 1	
17. INFORMANT Mrs. Mary L. Schwartz		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Febr. 19, 1966 , to March 4, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 11:00 a.m. , from causes and on the date stated above.			
22a. SIGNATURE Cesario J. Pellegrino		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED March 4, 1967
22c. PHYSICIAN'S NAME (Type) Cesario J. Pellegrino		22d. ADDRESS 6800 Loch Raven Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/7/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03351

CERTIFICATE OF DEATH

03343

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>4024 Coldspring Lane</u>	
3. NAME OF DECEASED (Type or print) <u>YETTA</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30</u> AGE (In years last birthday) <u>30</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Laib Brodie</u>	
14. MOTHER'S MAIDEN NAME <u>Leah ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>205-14-4231</u>		17. INFORMANT <u>Mr. Joseph Sitnick, 4024 W. Cold Spring Lane</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SUSPECTED OCCLUSION OF AORTIC BIFURCATION</u> DUE TO (b) <u>16 HRS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>HEATH</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ULCERATIVE COLITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/18/67</u> , 19 <u>67</u> , to <u>3/24/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/24/67</u> , 19 <u>67</u> , and that death occurred at <u>8:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Irvin Hyatt Ormrod</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DR IRVIN HYATT</u>		22d. ADDRESS <u>Baltimore Co. General Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tifereth Israel Anshe Shard</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Lewenson & Sons, Inc. 6010 Rust. Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

03352

CERTIFICATE OF DEATH

Reg. Dist. No. 03344

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 Coleridge Court, Apt. E				d. STREET ADDRESS 1002 Coleridge Court, Apt. E			
3. NAME OF DECEASED (Type or print) Mildred F. Sline				4. DATE OF DEATH Mar. 25 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 1, 1907	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Upholstery Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Franklin H. Barto				14. MOTHER'S MAIDEN NAME Emma L.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-07-0828		INFORMANT Address 21228 Mrs. Irvin R. Waterfield, 1322 Denbriht Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1967 METASTATIC CARCINOMA - Left 1967 DUE TO Tumor - Skull - Pelvic Bones Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Jan 11 , 1966, to Mar 26 , 1967, that I last saw the deceased alive on Mar 25 , 1967, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1115 N. CALVERT ST. DATE SIGNED JOSEPH S. BLUM M.D.							
ACTUAL SIGNATURE JOSEPH S. BLUM M.D.		PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 28, 1967	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Harry H. Witzke, 4101 Edmondson Ave., Balto. 29, Md.				24a. REC'D BY REGISTRAR MAR 28 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03345

1. PLACE OF DEATH a COUNTY <u>Bolte</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Balti.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c LENGTH OF STAY IN lb <u>4 hrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELSTIE</u> Middle <u>C.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/04</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Janie Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>226-48 9678</u>	
17. INFORMANT <u>Jas. R. Smith</u>		Address <u>Cockeysville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u> </u> (b) <u>Hypertension</u> DUE TO <u> </u> (c) <u>Myocardial Infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10+ yrs</u> <u>16+ yrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22. DATE SIGNED <u>3/6/67</u>	
EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		Address (Street, city, town, or county) <u>Cockeysville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lough's</u>	23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Balt., Co. Md.</u>
24. FUNERAL DIRECTOR <u>Wm. L. Chatman Jr.</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>	
Address <u>1701 Mt. Cullow St. Balt., Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03354

03346

1 PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 221 Westowne Rd.		d. STREET ADDRESS 221 Westowne Rd.	
3 NAME OF DECEASED (Type or print) First Lillian Middle A. Last Smith		4. DATE OF DEATH Month March Day 29 Year 1967	
5. SEX female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1887
9 AGE (In years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Holmes		14. MOTHER'S MAIDEN NAME Mary Black	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 212-03-1730	
17. INFORMANT Mr. G. WALTER Smith		Address 505 Kingston Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) yellow phlebitis due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized Arteriosclerosis due to (c) Pericarditis Disease		INTERVAL BETWEEN ONSET AND DEATH Days Year Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1958 to 3/29 1967, that (I) (we) last saw the deceased alive on 3/28 1967, and that death occurred at 3 A M, from the causes and on the date stated above.			
22a. SIGNATURE James Nolan		22b DATE SIGNED 3/30/67	
22c. PHYSICIAN'S NAME (Type) J S NOLAN MD		22d ADDRESS Baltimore Md 21229	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF April 1, 1967	
23c NAME OF CEMETERY OR CREMATORY LEODIA PK.		23d. LOCATION (City, town, or county) (State) BALTO. Md.	
24 FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury, Sr.		25a REC'D BY REGISTRAR MAR 31 1967	
ADDRESS 6411 Windsor Mill Rd.		25b REGISTRAR'S SIGNATURE Charles Judge	

03355

CERTIFICATE OF DEATH

03347

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rendalls-town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>3129 Jeffland Road 7</u>	
3 NAME OF DECEASED (Type or print) <u>Clara E. Smithson</u>		4. DATE OF DEATH <u>3</u> Month <u>5</u> Day <u>1967</u> Year	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1880</u> 9 AGE (In years and birthday) <u>87</u> IS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Harford County</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William B. Smithson</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>220-44-1293 T</u>	
17. INFORMANT <u>Mr. James A. Smithson</u>		Address <u>same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prolonged hypotension - cardio-genic in origin 2° Ren.</u> DUE TO (b) <u>AS CPD.</u> DUE TO (c) <u>AS CPD.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 19 <u>67</u> , to <u>3-5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>67</u> , and that death occurred at <u>11:32 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3-5-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/8/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centre Methodist Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Forest Hill, Harford Co., Md.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Tinkner - same as above</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03356

CERTIFICATE OF DEATH

03348

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 310 E. RANDALL STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle B Last SOMERS				4. DATE OF DEATH Month MARCH Day 31 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 7, 1919		9. AGE (In years last birthday) yrs 48	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCKER ROOM ATTENDANT		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL BOARD		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARZA SOMERS				14. MOTHER'S MAIDEN NAME MARGARET SLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 216 09 97 42		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE YELLOW ATROPHY OF LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATOID ARTHRITIS DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH DAYS			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE. FRACTURE LEFT HIP							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that IV (this hospital) attended the deceased from MARCH 11, 1967 , to MARCH 31, 1967 , that IV (we) last saw the deceased alive on MARCH 31, 1967 , and that death occurred at 500A M. from causes and on the date stated above							
22a. SIGNATURE <i>George C. McElfatrick</i> M.D.				22b. DATE SIGNED 3/31/67		22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELFATRICK, M. D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4 3 67		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK		23d. LOCATION (City or town) (County) (State) RITCHIE HIGHWAY, BALTO. MD.	
24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME				25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

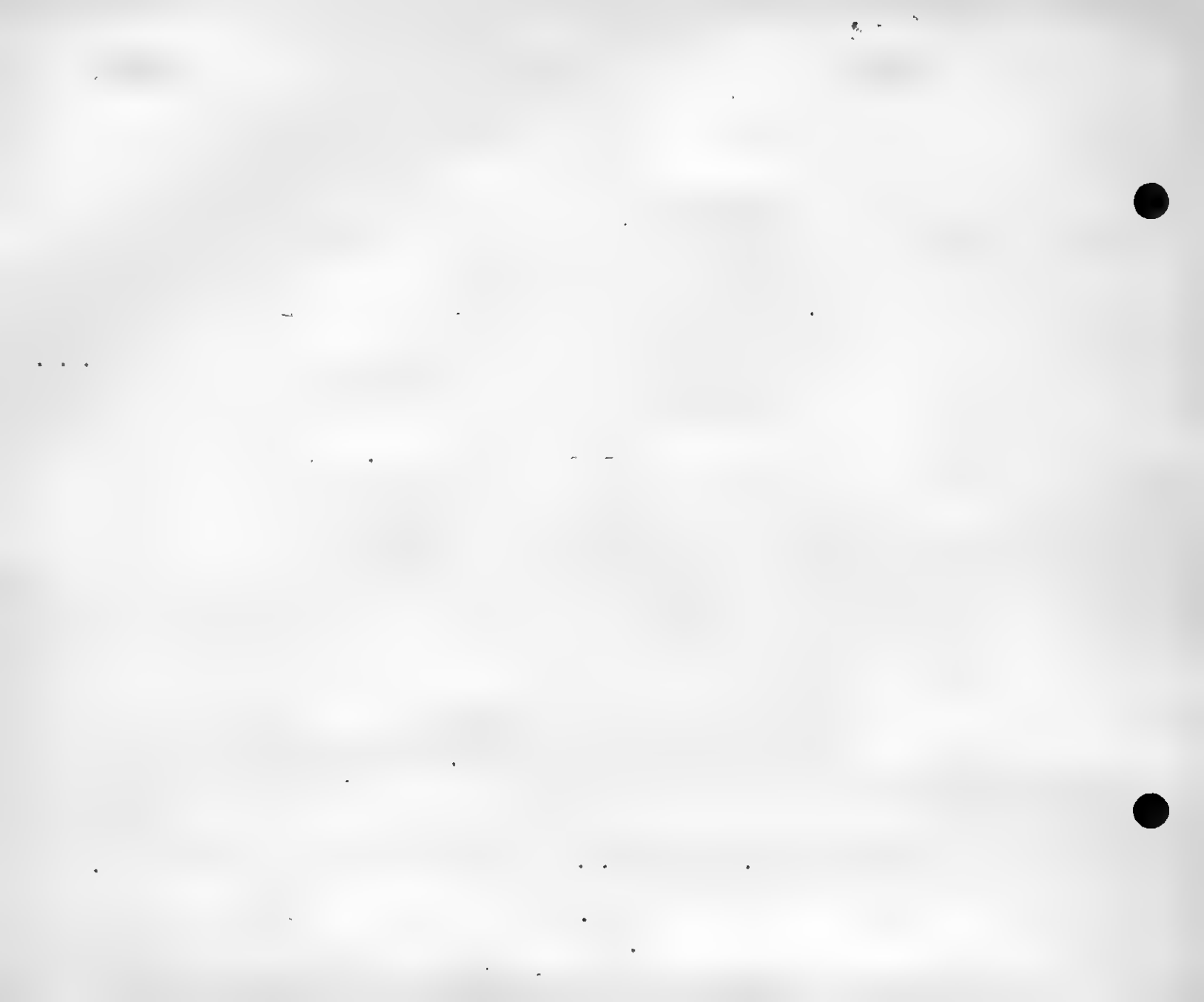
03357

CERTIFICATE OF DEATH

03349

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 55 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 5621 Wesley Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANGRISH Middle (NMI) Last SPEARMAN		4. DATE OF DEATH Month MARCH Day 2ND Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/94
9. AGE (In years last birthday) 72 (72 yrs)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Steamship Lines	
11. BIRTHPLACE (County & State, or foreign country) Fayetteville, North Carolina U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall Spearman		14. MOTHER'S MAIDEN NAME Rose Cogden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-09-33-31	
17. INFORMANT Clinical Rec. VAH, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 3 Days YEARS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 9 , 19 66 , to March 2 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 2 , 19 67 , and that death occurred at 1:20 PM , from causes and on the date stated above			
22a. SIGNATURE Louis C. Breschi, M.D.		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) LOUIS C. BRESCHI, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 7/67	23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Elliott Funeral Home		25a. REC'D BY REGISTRAR DATE MAR 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03358

CERTIFICATE OF DEATH

03350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c LENGTH OF STAY IN 1b <u>13-1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3315 Ripple Rd.</u>		d STREET ADDRESS <u>3315 Ripple Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>IRVIN SPECTOR</u>		4 DATE OF DEATH Month <u>MARCH</u> Day <u>18</u> Year <u>1967</u> 9PM 19	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 25, 1892</u>
9 AGE (In years last birthday) <u>74</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Poland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Unknown</u>	
14 MOTHER'S MAIDEN NAME <u>Unknown</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>217-03-8400</u>		17 INFORMANT <u>Mrs. Bertrum Kammerman - Same</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic myocardial infarction</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>66</u> to <u>3/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>67</u> and that death occurred at <u>9:15 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Dr. Leonard Golombeck</u>		22b DATE SIGNED <u>3/18/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. Leonard Golombeck</u>		22d ADDRESS <u>7039 Liberty Rd.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>3/20/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh Cong.</u>	23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>SOL LEVINSON & BROS INC. 6010 Reist Rd.</u>		25a REC'D BY REGISTRAR <u>MAR 22 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

03359

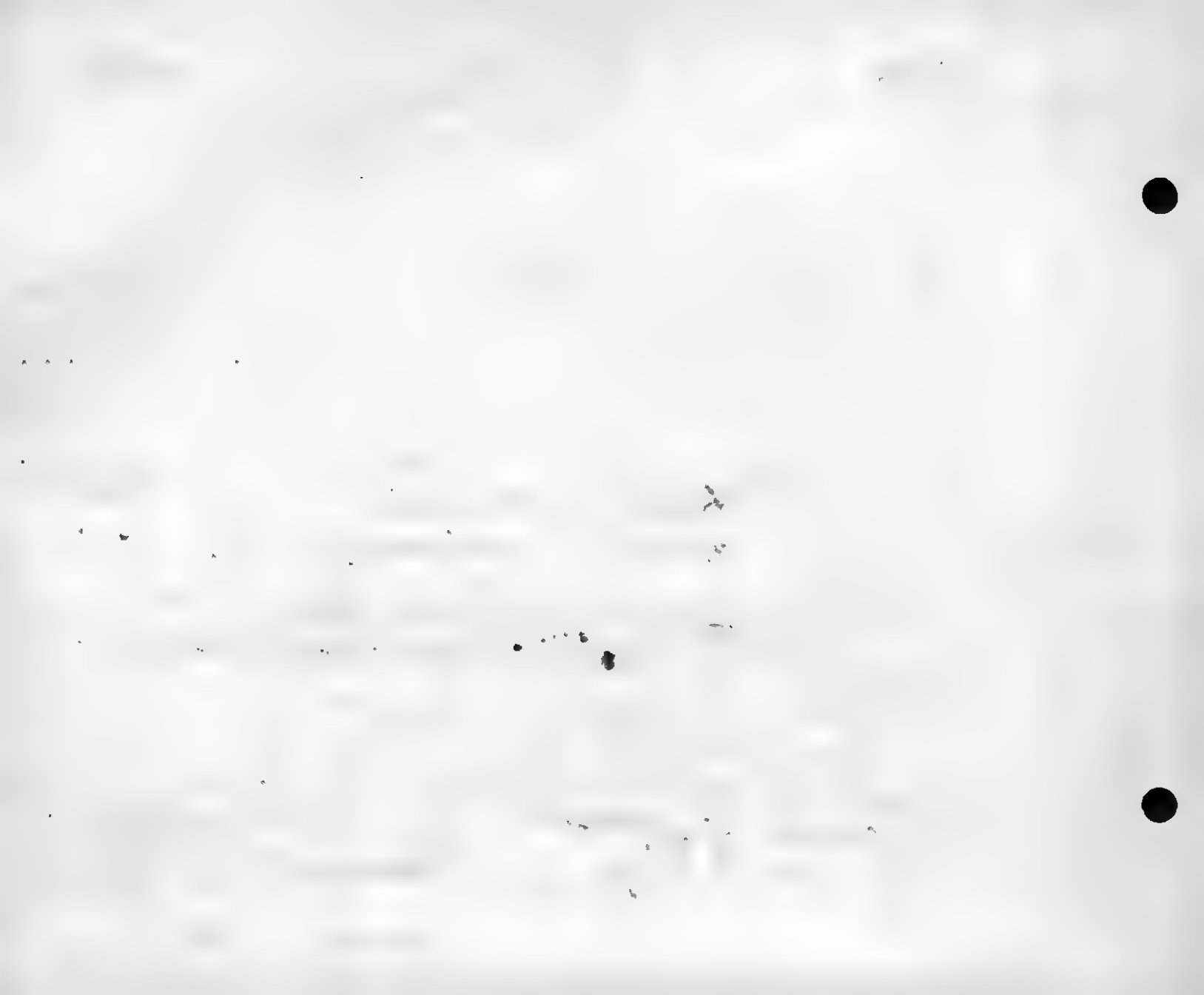
CERTIFICATE OF DEATH

03351

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN lb 3 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 924 Ashland Court	
3. NAME OF DECEASED (Type or print) First Monica Middle Yvonne Last Spellman		4 DATE OF DEATH Month 3 Day 11 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/62
9. AGE (In years last birthday) 4 yrs		10. IF UNDER 1 YEAR Months 0 Days 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Johns Hopkins Hosp.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Spellman		14 MOTHER'S MAIDEN NAME Yvonne Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Rosewood Records		Address Owings Mill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO Aspiration of stomach contents Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of stomach contents (c)		INTERVAL BETWEEN DEATH AND DEATH 24 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Kernicterus with Chronic Brain Syndrome			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 11-26 , 19 63 , to 3-11 , 19 67 , that (we) last saw the deceased alive on 3-11 , 19 67 , and that death occurred at 11:45 a.m. from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 14 Mar 67	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3/16/67	
23c NAME OF CEMETERY OR CREMATORY Rosewood		23d LOCATION (City or Town) (County) (State) Owings Mills Md	
24. FUNERAL DIRECTOR J F FELINE & Sons Reisterstown Md		25. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



D.D. Caples
6 Hanover Rd.
J.F. 3-2772

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03352

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON MD.		c. LENGTH OF STAY IN 1b 3 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEVENSON (VALLEY ROAD)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VALLEY ROAD			d. STREET ADDRESS		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First WILBUR Middle LEROY Last SPRECKER			4 DATE OF DEATH Month MARCH Day 6 Year 1967		
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 29 1913	9 AGE (n years last birthday) 53 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY —		11 BIRTHPLACE (State or foreign country) NEWVILLE, PA.	
13. FATHER'S NAME EARL SPRECKER			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR II			14 MOTHER'S MAIDEN NAME PEARL L. GORMAN		
16 SOCIAL SECURITY NO 213-05-1547			17 INFORMANT Address VALLEY ROAD MRS. MARY D. SPRECKER, STEVENSON, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 1/201 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE D. D. Caples M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22 DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd. Reisterstown, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY Greenwood Memorial Gardens	
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		ADDRESS		23d. LOCATION (City or town) (County) (State) Reisterstown, Md.	
25a. REC'D BY REG. STRIP MAR 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03361

CERTIFICATE OF DEATH

03358

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - ESSEX</u>				c. LENGTH OF STAY IN 1b <u>9 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Essex</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1642 Rickenbacker Road.</u>				d. STREET ADDRESS <u>1642 Rickenbacker Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>R.</u> Last <u>Squires</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 28, 1934</u>	9 AGE (In years last birthday) yrs. <u>32</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min.		IF UNDER 24 HRS Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Ratajczak</u>				14. MOTHER'S MAIDEN NAME <u>Rose Lhotsky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>212-34-2223</u>		17. INFORMANT <u>John T. Squires 1642 Rickenbacker Road.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma, transverse colon</u> DUE TO <u>c involvement of pancreas, mesentery</u> (b) <u>1 yr + ?</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>8-15</u> , 19 <u>66</u> , to <u>2-22</u> , 19 <u>67</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>3-22</u> , 19 <u>67</u> , and that death occurred at <u>11 E. Chase Street</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Francis A. Clark Jr</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS A. CLARK, JR</u>				22d. ADDRESS <u>11 E. Chase Street.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemox Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Philip E. Cruch 1211 Chesapeake Ave.</u>				25a. REQ'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03362

03354

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>607 Reisters town Rd.</i>				d. STREET ADDRESS <i>607 Reisters town Rd.</i>			
3. NAME OF DECEASED (Type or print) First <i>Theodore</i> Middle <i>S.</i> Last <i>Stansbury</i>				4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1967</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 29-1884</i>	
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Theodore S. Stansbury, Sr.</i>				14. MOTHER'S MAIDEN NAME <i>Jennie Merryman</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Howard S. Stansbury, 50 Linden Terrace</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Infarction</i>						<i>2 hrs</i>	
DUE TO (b) <i>Garphoraceous arteriosclerotic changes</i>						<i>(years)</i>	
DUE TO (c) <i>Virus - pneumonia</i>						<i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-1-66</i> to <i>3-26-67</i> , 19____, that (I) (we) last saw the deceased alive on <i>3-25-67</i> and that death occurred at <i>3:30</i> PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>James G. Saffell M.D.</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>3-27-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES G. SAFFELL</i>				22d. ADDRESS <i>6424 N St Reisters town, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 29, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION (City, town, or county) (State) <i>Pikesville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury Sr</i>				ADDRESS <i>4411 Windsor Mill Rd.</i>		25a. REC'D BY REGISTRAR <i>MAR 28 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

CERTIFICATE OF DEATH

03355

03363

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>General Hospital - Towson - Md.</u>		d. STREET ADDRESS <u>2617 Maryland Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Virginia St</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 4, 1897</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fulmer</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Frances H. Stierman 6-15</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 yrs</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>March 31, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 30, 1967</u> , and that death occurred at <u>9 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>March 31, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>H-E-33rd St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>4/3/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gracelawn Mem. Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wilmington, Del.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Fulmer & Sons</u>		25a. REC'D BY REGISTRAR <u>Baltimore, Md</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

03364

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03356

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL (Whitcomb Hall)</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL (Whitcomb Hall)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Graystone Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lewis</u> Last <u>Stielper</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 8, 1894.</u>	
9. AGE (in years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Stielper</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmena Schilp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-12-4701</u>		17. INFORMANT <u>Mrs. Mary T. Stielper</u> Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>4401 Coronary Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED <u>3/21/67</u> Address (Street, city, town, or county) <u>FARKTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

03365

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03357

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN ID 161 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balt. City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2038 Entaw Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Tommie Lee Stokes				4. DATE OF DEATH Month Day Year Mar 9 1967			
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-27-16	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tommie Stokes				14. MOTHER'S MAIDEN NAME Abby Sanders			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 416-26-1996			
17. INFORMANT Records, Mt. Wilson State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Tonsil. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Adv. Pul. Tuberculosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9-30 , 19 66 , to 3-9 , 19 67 , that (I) (we) last saw the deceased alive on 3-8 , 19 66 , and that death occurred at 3:30 M, from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				22b. DATE SIGNED 3-9-67			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-14-67		23c. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School		23d. LOCATION (City, town or county) (State) BALTIMORE, Md.	
24. FUNERAL DIRECTOR Harwell Funeral Home				25a. REC'D BY REGISTRAR Charles Judge			
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03366

CERTIFICATE OF DEATH

03358

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Baltimore b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c LENGTH OF STAY IN 1b 21212 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Baltimore c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d STREET ADDRESS 402 Radnor XXX. Rd. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Mabel Sena Mabel Stone		4 DATE OF DEATH Month Day Year March 1, 19 67	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1/10/86
9 AGE (In years last birthday) 81 yrs.		10 IF UNDER 1 YEAR Months Days Hours Min 12 CITIZEN OF WHAT COUNTRY? USA	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William N. Pearce		14 MOTHER'S MAIDEN NAME Mary Ann Griffin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-32-6547B	
17 INFORMANT Luther B. Stone		Address Above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of the toe (great) right foot		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 2/21 , 19 67 , to 3/1 , 19 67 , that (A) (we) last saw the deceased alive on 3/1/67 19 67 , and that death occurred at 3:28 PM , from causes on and on the date stated above.			
22a. SIGNATURE Eduardo Canilang		22b. DATE SIGNED 3-1-67	
22c. PHYSICIAN'S NAME (Type) Eduardo Canilang, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-4-67	
23c. NAME OF CEMETERY OR CREMATORY St. Marys Episcopal		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

03367

CERTIFICATE OF DEATH

03359

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>3-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		e. STREET ADDRESS <u>3801 Labyrinth Road</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>STRAUSS</u> Last <u>STRAUSS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Milwaukee, Wisconsin</u>
13. FATHER'S NAME <u>Abraham Fredman</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Richenbaum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Miriam Selznick</u>		Address <u>3801 Labyrinth Road</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> DUE TO <u>4-5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4-5</u> (b) <u>distal embolus</u> (c) <u>4-5</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1967</u> to <u>3/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> 19 <u>67</u> and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Milton Kirsch</u>		22b. DATE SIGNED <u>3/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Milton Kirsch</u>		22d. ADDRESS <u>4000 W. Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Springhill</u>	23d. LOCATION (City or Town) (County) (State) <u>Milwaukee, Wisconsin</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	

MAR 22 1967

03368

CERTIFICATE OF DEATH

03368

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooper'sville</u>		c. LENGTH OF STAY IN 15 <u>15 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Homes</u>		d. STREET ADDRESS <u>1925 Wilkins Ave</u>	
3 NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>Elsie</u> Middle <u>Stroh</u> Last		4 DATE OF DEATH <u>March 30</u> 19 <u>67</u> Month Day Year	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1892</u> 94 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	
11. BIRTH PLACE (County & State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>Balthasar Stroh</u>		14 MOTHER'S MAIDEN NAME <u>Marie Schmehl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-54-6337-5</u>	
17. INFORMANT <u>Records of Md. Masonic Home</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO <u>acute urinary tract obstruction</u> (b) <u>and infection</u> DUE TO <u>Cerebrovascular accident & Senility</u> (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> , to <u>March 30</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 29</u> 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. Hamel MD</u>		22b. DATE SIGNED <u>3/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED MD</u>		22d. ADDRESS <u>MASONIC HOME, Cockeysville</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon, Baltimore</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, MD.</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u>		25a. REC'D BY REGISTRAR <u>APR 3 1967</u>	
ADDRESS <u>Towson, Md. 21204</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~other~~ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03369

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03361

1. PLACE OF DEATH a COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY ---			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FBRT HOWARD			c LENGTH OF STAY IN 1b 95 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d STREET ADDRESS 2907 BOARMAN AVENUE		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last OLIVER -- STROSNIER				4 DATE OF DEATH Month Day Year MARCH 6 19 67			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 16, 1892		9 AGE (n years last birthday) yrs. 74	10 IF UNDER 1 YEAR Months Days Hours Min ---	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10b KIND OF BUSINESS OR INDUSTRY TAXICAB		11 BIRTHPLACE (State or foreign country) WARDENSVILLE, WEST VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL STROSNIER				14. MOTHER'S MAIDEN NAME SUSAN KECKLEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16 SOCIAL SECURITY NO 212 18 38 09		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) Fracture & subluxation. Right hip - 5 1/2 mos DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH ---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Granulocytopenia							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fall at home					
20c TIME OF INJURY Month, Day, Year Hour a.m. 9-18 19 66 p.m. ---		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office, school, etc.) Home		20f CITY OR TOWN (County) (State) Balt. Md 21215	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE MELVIN B. DAVIS, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) MELVIN B. DAVIS, M. D.				6800 MORNINGTON ROAD, BALTIMORE, MD. 21222			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3/9/67		23c NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL		23d LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND	
24 FUNERAL DIRECTOR Joseph N. Zannino				ADDRESS 257 S. Conkling St. Baltimore, Md.		25a REC'D BY REGISTRAR DATE 3/6/67	
				25b REGISTRAR'S SIGNATURE ---		22. DATE SIGNED 3/6/67	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03370 CERTIFICATE OF DEATH 03362											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						d. STREET ADDRESS 6501 Regate Circle					
3. NAME OF DECEASED (Type or print) First Bridget Middle K. Last Sullivan						4. DATE OF DEATH Month March Day 29 Year 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1887		9. AGE (in years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Peter KELLY						14. MOTHER'S MAIDEN NAME Ellen HOARE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 				16. SOCIAL SECURITY NO. 073-12-4568D		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of parotid gland.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (X) (this hospital) attended the deceased from Feb. 27, 1967 , to 3/29, 1967 , that (I) (we) last saw the deceased alive on 3/29, 1967 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Narciso W. Chamon M.D.						22b. DATE SIGNED 3/29/67					
22c. PHYSICIAN'S NAME (Type) NARCISO W. CHAMON						22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 4-1-1967		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTO. MARYLAND			
24. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE						25a. REC'D BY REGISTRAR 31 MAR 1967					
25b. REGISTRAR'S SIGNATURE Charles Judge											

03371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03363

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Balto. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY in 1b Randallstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. Gen. Hosp.		d. STREET ADDRESS 3820 Cassandra Rd.	
3 NAME OF DECEASED (Type or print) First Solomon Middle Lyons Last Taks		4 DATE OF DEATH Month Mar. Day 19 Year 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 9, 1911
9 AGE (in years last birthday) 55 yrs		10 IF UNDER 1 YEAR Months 19 Days 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Flooring Bus.	
11 BIRTHPLACE (State or foreign country) New York City, N. Y.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Phillip Taks		14 MOTHER'S MAIDEN NAME Hannah ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) no		16 SOCIAL SECURITY NO 113-12-5031	
17 INFORMANT Mrs. Rebecca Taks, 3820 Cassandra Rd.,		Address Randallstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/21/67	
23c. NAME OF CEMETERY OR CREMATORY Mikro Kodesh Beth Israel		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd.		25a. REC'D BY REGISTRAR MAR 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 3-20-67	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND									
03372 CERTIFICATE OF DEATH 05504									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>BALTIMORE</u> b. COUNTY <u>MARYLAND</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			d. STREET ADDRESS <u>9 DUNKIRK ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>STELLA</u> First <u>OSANG</u> Middle <u>Talbot</u> Last					4. DATE OF DEATH <u>3</u> Month <u>11</u> Day <u>23</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/82</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE M LEWIS</u>					14. MOTHER'S MAIDEN NAME <u>CORA PRYOR</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO. <u>218-52-4671</u>		17. INFORMANT Address <u>Mrs. John I. DeMoss Same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic and Respiratory Arrest.</u> <u>4330</u> DUE TO (b) <u>Heart failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerotic Cardio Vasc Disease.</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E. LARRABEE</u>					22d. ADDRESS <u>G. B. M. C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3-27-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Mitchell Wiedefeld Home, Inc.</u> <u>6500 York Rd. Baltimore, Md. 21212</u>					25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



12

1. The first part of the document is a list of the names of the persons who were present at the meeting. The names are listed in alphabetical order.



2. The second part of the document is a list of the names of the persons who were present at the meeting. The names are listed in alphabetical order.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03373

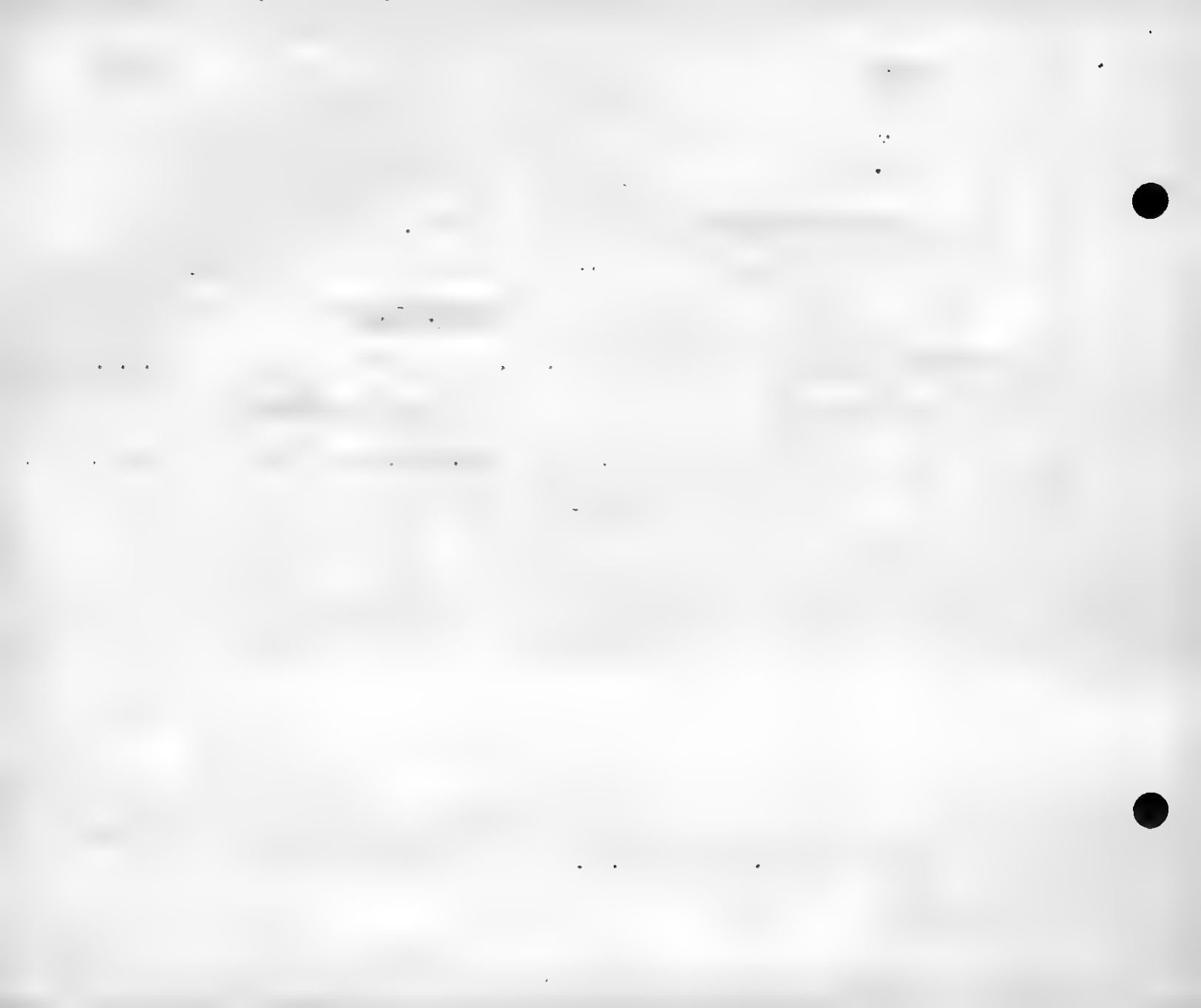
CERTIFICATE OF DEATH

03365

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN Ib 9 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH -- TAYLOR		4. DATE OF DEATH Month Day Year MARCH 29 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH [REDACTED]
9. AGE (in years last birthday) 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPREADER & CUTTER		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG. CO.	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (ROMERO BROS.) ABRAHAM TAYLOR		14. MOTHER'S MAIDEN NAME HURWITZ MINNIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO 212 01 66 66	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 271A DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE AND CEREBRAL ARTERIOSCLEROSIS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from 3/20/67 , 19 67 , to 3/29/67 , 19 67 , that he (we) last saw the deceased alive on 3/29/67 , 19 67 , and that death occurred at 4:35AM from causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE SIGNED 3/29/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/30/67	23c. NAME OF CEMETERY OR CREMATORY ANSHE NESINA	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON BROTHERS		25a. REC'D BY REGISTRAR APR 3 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03374

CERTIFICATE OF DEATH

03366

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21212 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 d. STREET ADDRESS 6625 Loch Raven Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Tracey Taylor		4. DATE OF DEATH Month Day Year March 20, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1967
9. AGE (In years last birthday) 5 yrs		10. IF UNDER 1 YEAR Months Days 5 49	11. IF UNDER 24 HRS. Hours Min. 5 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Towson, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Insley, Raymond		14. MOTHER'S MAIDEN NAME Tracey, Kathleen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that NO (this hospital) attended the deceased from March 20, 19 67 , to March 20, 1967 , that NO (we) last saw the deceased alive on March 20, 19 67 , and that death occurred at 9 A.M. from causes and on the date stated above.			
22a. SIGNATURE Jose X. Aguto		22b. DATE SIGNED March 20, 1967	
22c. PHYSICIAN'S NAME (Type) Jose Aguto, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-22-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE MAR 23 1967	
		25b. REGISTRAR'S SIGNATURE	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03375

CERTIFICATE OF DEATH

03367

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 68 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2139 N. SMALLWOOD STREET	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK M. THOMAS		4. DATE OF DEATH Month Day Year MARCH 9 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1893
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE CLUB	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN THOMAS		14. MOTHER'S MAIDEN NAME MARGARET SHEPPERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO 215 07 09 20	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO (b) COLIFORM BACTERIA DUE TO (c) CYSTITIS, CHRONIC		INTERVAL BETWEEN ONSET AND DEATH HOURS WEEKS WEEKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ADENOCARCINOMA OF PROSTATE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 1/30/67 , 19__ to 3/9/67 , 19__, that (b) (we) last saw the deceased alive on 3/9/67 , 19__, and that death occurred on 2:35 PM , from causes on and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Irvin P. Carroll</i>		25a. REC'D BY REG STRAR IRVIN P. CARROLL FUNERAL HOME DATE MAR 13 1967 1712 W. North Ave. Baltimore, Md.	
		25b. REG STRAR'S SIGNATURE <i>J. Charles Judge</i>	

03376

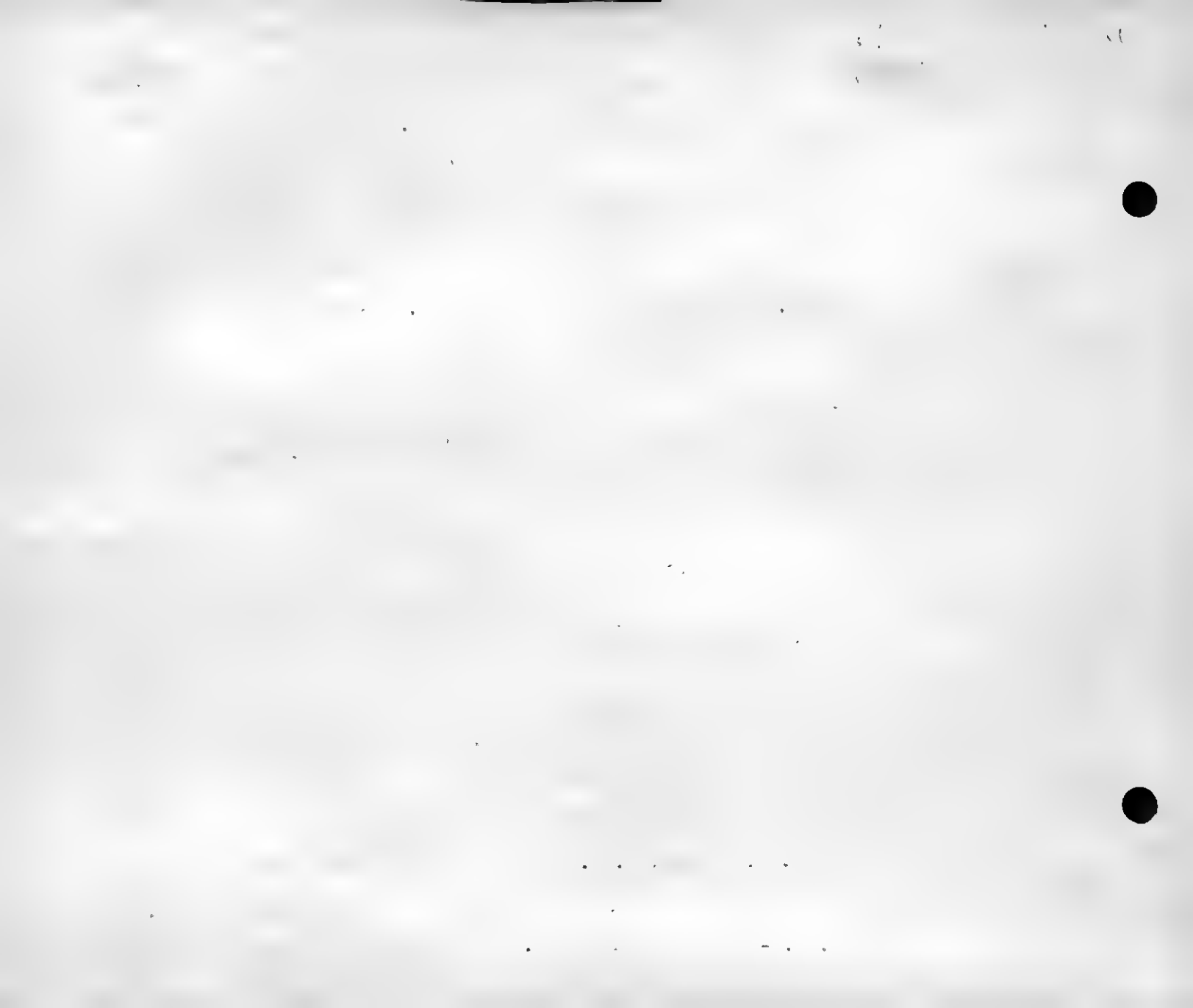
CERTIFICATE OF DEATH

03368

1. PLACE OF DEATH a. COUNTY baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) catonsville		c. LENGTH OF STAY IN 1b 603 Wildwood Parkway - Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		d. STREET ADDRESS 603 Wildwood Parkway	
3. NAME OF DECEASED (Type or print) Margaret Ann Tipman		4. DATE OF DEATH Month Day Year March 13 19 67	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15, 1885
9. AGE (In years lost birthday) 82 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Fethe		14. MOTHER'S MAIDEN NAME Margaret Bardroff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Katherine Denbo 2011 Woodlawn Dr. - 21207		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Colorectal fistula</u> DUE TO (c) <u>Colostomy</u>			INTERVAL BETWEEN ONSET AND DEATH 2 days 4 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Arteriosclerosis</u>			19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 1967, to 3/13, 1967 that (I) (we) last saw the deceased alive on 3/13, 1967, and that death occurred at 3P. M. from causes and on the date stated above			
22a. SIGNATURE D. P. Alagia		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type) D. P. Alagia, M. D.		22d. ADDRESS 3326 Frederick Avenue	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-16-67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR MAR 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1
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03377

CERTIFICATE OF DEATH

03369

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 16 years Valley View Apts. Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Armacost Nursing Home		d. STREET ADDRESS 7736 Greenway Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ELIZABETH B. TIPTON		4 DATE OF DEATH March 17, 1967	
5 SEX female		6 COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 25, 1886	
9 AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min. 19	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11b. KIND OF BUSINESS OR INDUSTRY Home	
11c. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barrett		14. MOTHER'S MAIDEN NAME Elizabeth Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 220-44-1575	
17. INFORMANT John H. Hissey, 1311 Fidelity Bldg., Balto.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ape plexy DUE TO (b) Arterio-sclerosis DUE TO (c) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1939 to 17 March 1967 that (I) (we) last saw the deceased alive on 17 March 1967 , and that death occurred at 10 M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Reier		22b. DATE SIGNED March 20, 1967	
22c. PHYSICIAN'S NAME (Type) Charles H. Reier, M.D.		22d. ADDRESS 6701 York Road, Baltimore, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204		25a. REC'D BY REGISTRAR MAR 22 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>033770</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 402 Carolina Road						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 402 Carolina Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Peter W. Traynor, Sr.						4. DATE OF DEATH Month Day Year March 9 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/1883		9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Engineer				10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Traynor						14. MOTHER'S MAIDEN NAME Elizabeth Willoughby					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ella D. Traynor (Same)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of sigmoid DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1967</u> to <u>March 9, 1967</u>, that (I) (we) last saw the deceased alive on <u>March 8, 1967</u>, and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE Dr. Allan A. Spier						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/10/67			
22c. PHYSICIAN'S NAME (Type) Dr. Allan A. Spier						22d. ADDRESS 1501 Pentridge Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.						25a. REC'D BY REGISTRAR 4905 York Road		25b. REGISTRAR'S SIGNATURE Charles Judge			
ADDRESS Balto. 12, Md.						DATE MAR 10 1967					

MEDICAL CERTIFICATION



03379

03371

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1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6835 BLENHEIM RD</u> d. STREET ADDRESS <u>6835 BLENHEIM</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AZILE</u> Middle <u>NMN</u> Last <u>TROUP</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/29/1892</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WILMINGTON N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY HEWLETT</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET BENDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>220-45-4145</u>	
17. INFORMANT <u>PATIENT CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMOCOCCAL PERICARDITIS AND MYOCARDITIS WITH HEMORRHAGE AND TAMPONADE</u> (b) <u>AND TAMPONADE</u> (c) <u>PNEUMOCOCCAL BACTEREMIA</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEPTICEMIA FROM PNEUMOCOCCAL ARTHRITIS</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 14th, 1967</u> to <u>March 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 18, 1967</u> , and that death occurred at <u>3:40 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. I. Mac Gressor</u>		22b. DATE SIGNED <u>3-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. I. MAC GRESSOR</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>6500 York Rd. Baltimore, Maryland 21212</u>		DATE <u>MAR 27 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

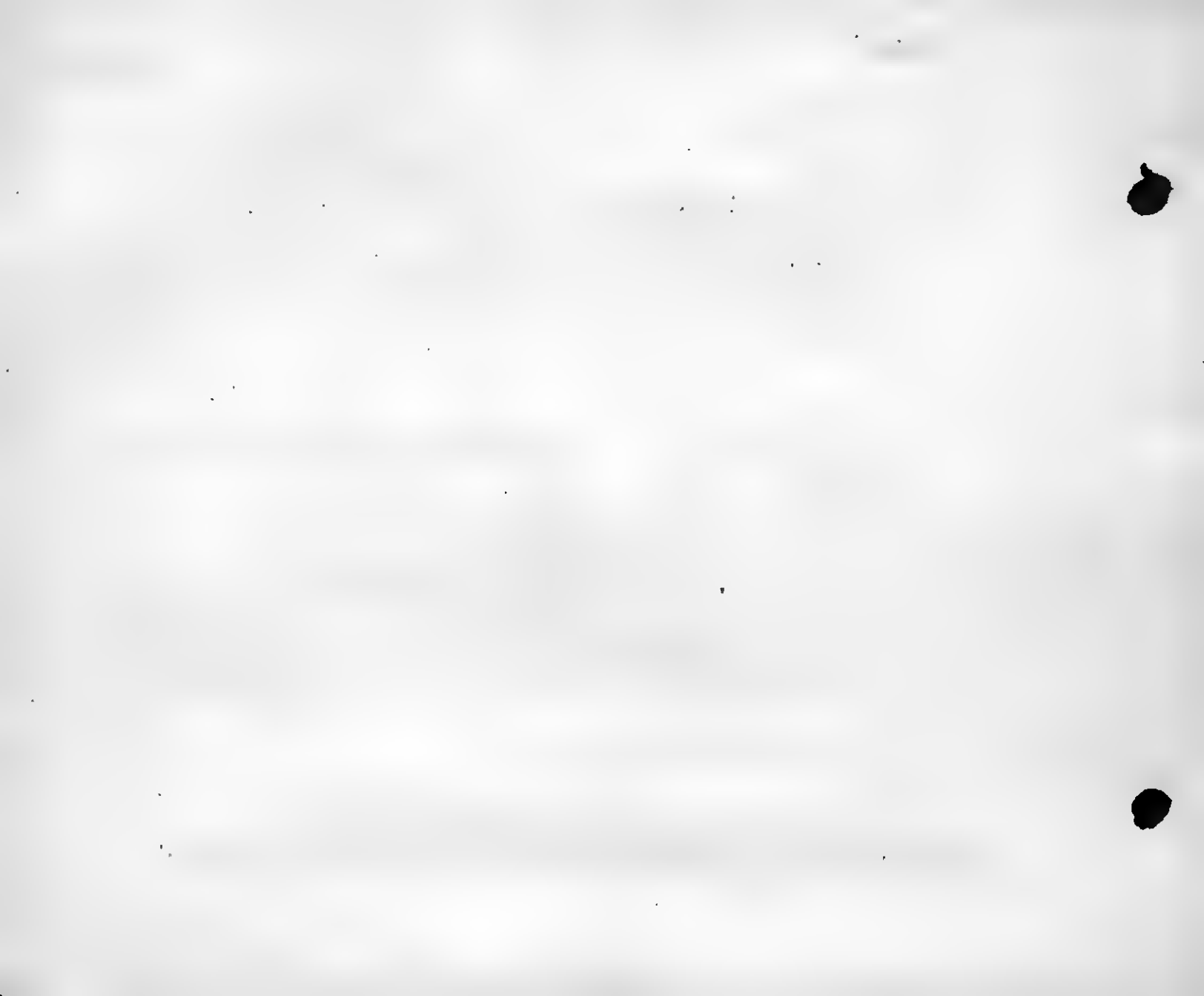
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03380

03372

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Yoppa d. STREET ADDRESS 2608 Mountain Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BERTHA Middle Uhlik 5. SEX F 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		4. DATE OF DEATH March 21 1967 8. DATE OF BIRTH 4-21-01 9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry 10b. KIND OF BUSINESS OR INDUSTRY CL. 11. 46 11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia 12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Radoslaw Priborsky 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) —		14. MOTHER'S MAIDEN NAME Maria Jozefina 16. SOCIAL SECURITY NO. 213-10-3164 17. INFORMANT Records, Mt. Wilson State Hospital Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE (b) ACUTE PYELITIS (c) MEDULLARY CARCINOMA OF BREAST PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from March 16, 1967, to March 21, 1967, that (I) (we) last saw the deceased alive on March 21 1967, and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22b. DATE SIGNED 3/22/67 22d. ADDRESS Mount Wilson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY BOHEMIAN NATIONAL 23d. LOCATION (City, town or county) (State) BALTIMORE MD		25a. REC'D BY REGISTRAR MAR 27 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge			



03381

CERTIFICATE OF DEATH

03373

1 PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN b 1 wk.		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Balt. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		d. STREET ADDRESS 714 Greenwood Rd	
3. NAME OF DECEASED (Type or print) William Suidy ULRICH		4. DATE OF DEATH Month March Day 12 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-97
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Mr. Crowley Co.	9. AGE (In years last birthday) 69 yrs
11. BIRTHPLACE (County & State, or foreign country) Kd.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Urich		14. MOTHER'S MAIDEN NAME Mary Shields	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-3754	
17. INFORMANT Records, Mount Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Manive Hemoptysis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) probable pulmonary tuberculosis DUE TO (c) 10 years (2-4 yrs)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-3-67 to 3-4- , 19 67 that (I) (we) last saw the deceased alive on 3-11 19 67 , and that death occurred at 11:45 AM , from causes and on the date stated above			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 3-11-67	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 15, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Balt. Co.	
24. FUNERAL DIRECTOR Novell Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Pikesville - 9 - Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03382

CERTIFICATE OF DEATH

03374

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Conv. Home</u>				d. STREET ADDRESS <u>26 NEWBURG AVE</u>			
3. NAME OF DECEASED (Type or print) <u>M. REGINA UPMAN</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/77</u>	9. AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEC.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>
13. FATHER'S NAME <u>JOHN B. UPMAN</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN M. PATTERSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>212031591</u>		17. INFORMANT <u>PAUL KAEHLER</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>4221</u> <u>Cerebral Vascular Thrombosis</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease with chronic congestive Heart Failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Dissecting aortic aneurysm</u> (c) <u>Heart Failure.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days.</u> <u>5 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(3) Unrelieved Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town), (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/27/67</u> 19 <u>67</u> to <u>3/4/67</u> 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>2/28/67</u> , and that death occurred at <u>154</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>W E McGrath MD</u>				22b. DATE SIGNED <u>3/2/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W E McGrath MD</u>	
22d. ADDRESS <u>1303 Frederick Rd</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>	
24. FUNERAL DIRECTOR <u>E. S. MACNAB</u>				25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03383						03375					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville						b. COUNTY Prince George					
c. LENGTH OF STAY IN ID 10yr11mth16dys						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Maryland Park, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						d. STREET ADDRESS 6412 East Street A.E.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Rebecca			Middle A			Last Vance		
4. DATE OF DEATH			Month March			Day 15			Year 19 67		
5. SEX female			6. COLOR OR RACE white			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Sept. 30, 1882 84		
9. AGE (In years last birthday) yrs.			10. IF UNDER 1 YEAR Months			11. IF UNDER 24 HRS. Days			12. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U. S		
13. FATHER'S NAME John Samuel VANCE						14. MOTHER'S MAIDEN NAME Eva SINGER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 219-54-3454T			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated assoc. cerebral arterioscler.											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from March 29, 1956, to March 15, 1967, that (we) last saw the deceased alive on March 15, 1967, and that death occurred at 11:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature] M.D.						22b. DATE SIGNED 3-16-67					
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 3/18/67			23c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L			23d. LOCATION (City, town or county) (State) GUTHRIE M.D.		
24. FUNERAL DIRECTOR Will Chambers Co. 5714 1/2 E. WASH D.C.						25a. REC'D BY REGISTRAR MAR 20 1967					
25b. REGISTRAR'S SIGNATURE [Signature]											

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Reside in home (admission)) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWSON		c. LENGTH OF STAY IN TB 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTRE		d. STREET ADDRESS BOX 299 BAUBLITZ	
3. NAME OF DECEASED (Type or print) GEORGE GLOVER VANDERVEER		4. DATE OF DEATH Month MARCH Day 21st Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-8-03
9 AGE (In years last birthday) 63 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE ACCOUNTANT		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) LONG ISLAND N.Y.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. VANDERVEER		14. MOTHER'S MAIDEN NAME LOTTIE BAIRD	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO. 215-07-1007	
17 INFORMANT MRS. MIRIAM B. VANDERVEER (SAME)		Address	
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of left bronchus. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day Year Hour o.m. _____ p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20, 1967 , to March 21, 1967 that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 11:05 PM , from causes and on the date stated above.			
22a SIGNATURE Dr. Isabelle MacGregor M.D.		22b DATE SIGNED 3-21-67	
22c PHYSICIAN'S NAME (Type) ISABELLE MAC GREGOR		22d ADDRESS Gre. Balt. Medical Centre	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	3/22/1967	Greenmount	Baltimore, Md.
24 FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.		25a REC'D BY REGISTRAR DATE MAR 23 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

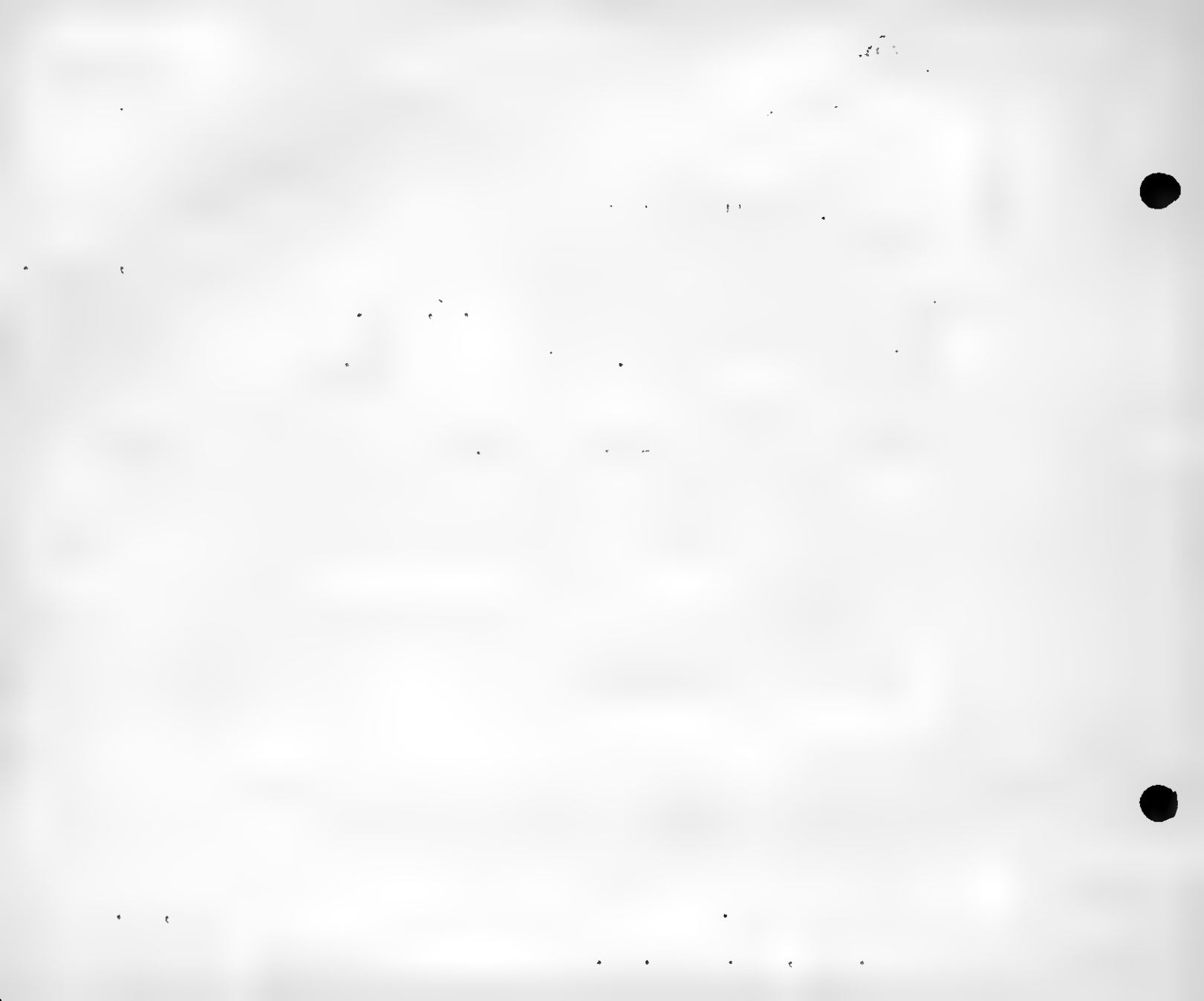
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03385

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03377

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Towson			c. LENGTH OF STAY IN TB			c. CITY OR TOWN (If outside corporate limits write RURAL, and give nearest town) Baltimore 21204	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital				d. STREET ADDRESS 809 Shelley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOSEPH Last VERRIER				4. DATE OF DEATH Month March Day 27 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov. 6, 1902.	
9. AGE (In years last birthday) 64 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Balto. County		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Joseph Verrie			
14. MOTHER'S MAIDEN NAME Lucinda Gauthier				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-12-3308				17. INFORMANT Mrs. Mary Sabella Address (Same)			
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 441X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ulceroative Bronchitis (c) Bronchial Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 48 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town or county)			
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/3/67.		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03386

CERTIFICATE OF DEATH

03386

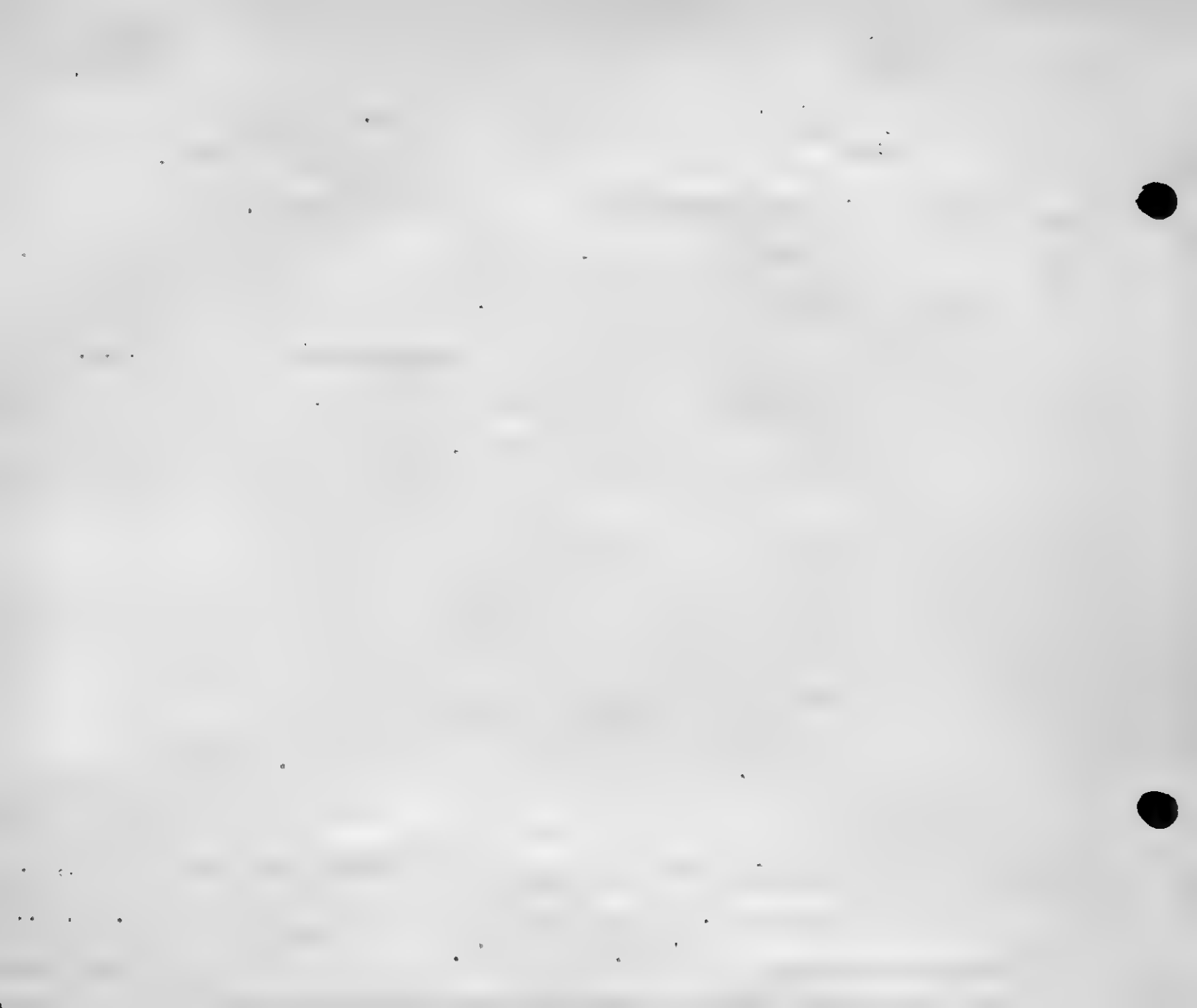
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 63 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21217		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 585 PRESSTMAN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle -- Last WADE				4. DATE OF DEATH Month MARCH Day 29 Year 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 1, 1909	
9. AGE (In years last birthday) 57 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAREHOUSEMAN		10b. KIND OF BUSINESS OR INDUSTRY CARPET COMPANY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HARRY WADE			
14. MOTHER'S M A DEN NAME FLORENCE WASHINGTON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II			
16. SOCIAL SECURITY NO. 218 10 55 80				17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT UPPER LOBE DUE TO (b) ATELECTASIS AND INFARCTION OF RIGHT LOWER LOBE, RT LUNG DUE TO (c) BRONCHOPNEUMONIA PULMONARY EDEMA AND CONGESTION OF LEFT LUNG INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour --- a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/25/67 , 19 67 , to 3/29/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/29/67 , 19 67 , and that death occurred at 2:30 A.M. , from causes and on the date stated above							
22a. SIGNATURE <i>Milton Ginsberg</i>				22b. DATE SIGNED 3/29/67		22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND				22e. MED. DIRECTOR <input type="checkbox"/> MED. STAFF <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-3-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Kelson Funeral Home</i>				25a. REC'D BY REGISTRAR APR 3 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03387					03379				
1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore # 21224				
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore # 21224			d. STREET ADDRESS 643 S. Oldham St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney - Towson Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROSE A. WALLNER					4. DATE OF DEATH March 27, 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Aug. 22, 1889		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Rehak					14. MOTHER'S MAIDEN NAME Maria ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. John J. Wallner				
17. INFORMANT Same					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Pulmonary Embolus (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 7 weeks 7 weeks					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/1/67 9:40 P.M. 3/27/67 , that (I) (we) last saw the deceased alive on 3/27 1967 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE Joseph A. Sedlaack					22b. DATE SIGNED 3/28/67				
22c. PHYSICIAN'S NAME (Type) Joseph A. Sedlaack					22d. ADDRESS 200 W. Pennsylvania Ave., Towson, 4, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-30-67		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery			23d. LOCATION (City, town or county) (State) 7401 German Hill Rd., Ba. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles J. Jailer					25. REG'D BY REGISTRAR MAR 31 1967				
25b. REGISTRAR'S SIGNATURE Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03388

Item #12 Film #3388 3/14/67
Item #3 Film #3388 3/14/67

CERTIFICATE OF DEATH

03380

1. PLACE OF DEATH a COUNTY <u>Baltimore</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c LENGTH OF STAY IN b <u>15</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summit Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>-</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d STREET ADDRESS <u>414 Rosecroft Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Kerdock</u> Middle <u>Vera / Valunas (Valunas)</u> Last <u>-</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>wh</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 1890</u>		9. AGE (in years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuanian</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Govelis</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO <u>21 6 09 7218</u>		17. INFORMANT <u>Daniel Kerdock</u> Address <u>402 Rosecroft Terrace</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Q. S. Congestive heart failure.</u> (b) <u>-</u> (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>March 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 3 1967</u> , and that death occurred at <u>2 A.M.</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Stanley Ankudas</u>				22b. DATE SIGNED <u>3/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Stanley Ankudas, M.D.</u>	
22d. ADDRESS <u>1101 Maiden Choice Lane #21229</u>				22e. REC'D BY REGISTRAR <u>Thomas J. Kerrin Inc 1500 Hollins St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR <u>Thomas J. Kerrin Inc 1500 Hollins St</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03389

CERTIFICATE OF DEATH

03381

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM WARD				4. DATE OF DEATH Month March , Day 8 , Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-1892	
9. AGE (in years) 74 yrs		10. UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME James Ward				14. MOTHER'S MAIDEN NAME Delia Lagan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Regina L. Ward, 3368 Dulaney St. 29	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1. Cerebral Thrombosis Multiple DUE TO (b) 2. Gangrene left distal leg & foot DUE TO (c) 3. Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH 6 months 4 days 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4. Decubiti Multiple				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/16/67 to 3/8/67 , that (I) (we) saw the deceased alive on 3/7/67 , and that death occurred at 6:20 A.M. from causes and on the date stated above.				22a. SIGNATURE W.E. McGrath M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 3/9/67			
22c. PHYSICIAN'S NAME (Type) Dr. W.E. McGrath				22d. ADDRESS 1303 Frederick Road, Balto., Md. 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-11-1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229				25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03383

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21207</u>		c. LENGTH OF STAY IN 1b <u>Unknown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2605 Gwynndale Ave. 21207</u>		e. STREET ADDRESS <u>2605 Gwynndale Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Elnora Wells</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/83</u>
9. AGE (In years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mildred Ritchie - 1454 Jefferson St</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO (b) <u>Arterio-Sclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>lost</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		20. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
21. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
23. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		24. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
25. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. 20f. (City or town) (County) (State)	
27. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		28. 22. DATE SIGNED	
29. ACTUAL SIGNATURE <u>James N. Frederick</u> M.D.		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
31. EXAMINER'S NAME (Type) <u>James N. Frederick</u>		32. Address (Street, city, town, or county)	
33. 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		34. 23b. DATE THEREOF <u>4-5-67</u>	
35. 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		36. 23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md</u>	
37. 24. FUNERAL DIRECTOR <u>ELLsworth Armacost</u>		38. 25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
39. 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		40. 26. ADDRESS <u>4600 Liberty Heights Ave</u>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03390

CERTIFICATE OF DEATH

03382

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2356 Research Avenue		d. STREET ADDRESS 2356 Research Avenue	
3 NAME OF DECEASED (Type or print) CHARLES GRAYSON WELDEN		4 DATE OF DEATH Month March Day 8 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 41
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Welden		14. MOTHER'S MAIDEN NAME Florence Thorn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 212-20-5366	17. INFORMANT Address Mrs. Dorothy M. Weldon, 2356 Research Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Right Lung DUE TO General Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 5 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/7 , 19 65 , to 3/8 , 19 67 , that (I) (we) last saw the deceased alive on 3/6 , 19 67 , and that death occurred at 4 M, from causes and on the date stated above			
22a SIGNATURE Elton W. Johnson		22b DATE SIGNED 3/9/67	22c PHYSICIAN'S NAME (Type) Dr. E.W. Johnson
22d ADDRESS 3432 Frederick Avenue, Balto., Md.			
23a BURIAL (CREMATION, REMOVAL (Specify)) BURIAL	23b DATE THEREOF 3-10-1967	23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a REC'D BY REGISTRAR MAR 10 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03392

CERTIFICATE OF DEATH

03384

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2204 Park Avenue	
3. NAME OF DECEASED (Type or print) WILLIE JAMES WILLIAMS		4. DATE OF DEATH Month March Day 12 Year 19 67	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/19
9 AGE (In years last birthday) yrs 47		IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Piano Company	
11 BIRTHPLACE (County & State, or foreign country) Jonesville, S. C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Williams		14. MOTHER'S MAIDEN NAME Ethel Durant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO 250 18 19 64	
17. INFORMANT Clinical Recds. VA Hospital, Ft Howard Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 445X IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, RIGHT LATERAL VENTRICAL DUE TO (b) -- DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LAENNEC'S CIRRHOSIS (FATTY LIVER) CHRONIC ALCOHOLISM		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from March 1 , 19 67 , to March 12 , 19 67 , that (X) (we) last saw the deceased alive on March 12 , 19 67 , and that death occurred at 11:30 M, from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson</i>		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Nutter Funeral Home		25a. REC'D BY REGISTRAR 3035 W. North Ave. Baltimore, Md. DATE MAR 14 1967	
25b. REGISTRAR'S SIGNATURE <i>Francis Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #43372, 3/27/67

03393

CERTIFICATE OF DEATH

03385

1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>BELAIR</u> ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c LENGTH OF STAY IN TB <u>2 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTRE</u>				e STREET ADDRESS <u>RT. 4 WESTMINSTER, MD 21157</u>		f IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WALTER CASSLE WIMERT</u>				4 DATE OF DEATH Month Day Year <u>MARCH 22 19 67</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8. 23. 1880</u>		9 AGE (In years last birthday) <u>86</u> yrs		IF UNDER 24 HRS Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STONE MASON AND BRICK LAYER</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>CARROLL COUNTY, MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>SAMUEL WIMERT</u>				14 MOTHER'S MAIDEN NAME <u>MARY</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>218-05-6220</u>		17 INFORMANT <u>PATIENT CHART</u> Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure.</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Acute myocardial infarction.</u> 2 days lost (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o m p m 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 21</u> , 19 <u>67</u> , to <u>March 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 22 1967</u> , and that death occurred at <u>1:00 P.M.</u> from causes and on the date stated above.							
22a SIGNATURE <u>M. Isabelle MacGregor</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b DATE SIGNED <u>3-22-67</u>	
22c PHYSICIAN'S NAME (Type) <u>M. ISABELLE MACGREGOR</u>				22d ADDRESS <u>Greater Baltimore Medical Centre.</u>			
23a BURIAL, CREMATION, RENOVAT (Specify)		23b DATE THEREOF <u>3/25/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Westminster, Md.</u>	
24 FUNERAL DIRECTOR <u>J. S. Myers Jr. Westminster, Md.</u>				25a REG'D BY REGISTRAR <u>MAR 27 1967</u> DATE		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

03394

CERTIFICATE OF DEATH

03387

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 103-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks 21152, Rt. 1. d. STREET ADDRESS 03-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Harry		First ZANDER		Middle ZANDER		Last ZANDER		4. DATE OF DEATH Month March Day 16 Year 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/06		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore Gas & Electric Co.		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Leonard W. Zander				14. MOTHER'S MAIDEN NAME Fannie Seidhoff					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-4680		17. INFORMANT Address Mrs. Emma J. Zander Sparks, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Pulmonary Thrombo-embolism								INTERVAL BETWEEN ONSET AND DEATH 4201	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Thrombo-embolism								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that Harry (this hospital) attended the deceased from March 3, 1967 , to March 16, 1967 , that he (we) last saw the deceased alive on March 16, 1967 , and that death occurred at 9:05 M. from causes and on the date stated above.									
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.				22b. DATE SIGNED March 20 1967				22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE-THEREOF 3/18/67		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City or Town) (County) (State) Finksburg, Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25. REGISTERED BY REGISTRAR Charles Judge				26. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03395

CERTIFICATE OF DEATH

03388

1. PLACE OF DEATH a. COUNTY <u>BALTO. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. Co</u>		c. LENGTH OF STAY IN TB <u>19 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1727 LYNCH Rd.</u>		d. STREET ADDRESS <u>1727 LYNCH Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>RT. REV. THOMAS B. ZINKAND</u>		4. DATE OF DEATH <u>MARCH 7, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-02</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RC CLERGYMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK ZINKAND</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. HERRON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT'S NAME <u>SISTER MARY THOMAS</u> Address <u>MERCY HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>—</u> , to <u>3/7/67</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>3-1-1967</u> , and that death occurred at <u>11A M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>S. Edwin Muller</u>		22b. DATE SIGNED <u>3/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. EDWIN MULLER</u>		22d. ADDRESS <u>1203 ST PAUL ST BALTO., MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-11-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO., MD</u>
24. FUNERAL DIRECTOR <u>J. Walter Conklin</u> ADDRESS <u>5444 BELAIR Rd.</u>		25a. REC'D BY REGISTRAR <u>MAR 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Walter Conklin</u>	

03330

03330

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